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ABSTRACT

The final report on facilitation of knowledge utilization by institutions for child development contains analyses of consultation-intervention in four different child care institutions (including psychiatric facilties and an orphanage), and a guide to providing individualized services in children's residential centers. Described in each case are actions taken by the consultants, interviews of staff members by an independent evaluator, and questionnaire data from institutional personnel. Also included are comments made by the project director and an analysis of overall results derived from two survey instruments (the Baseline Data Form and the Institution Self-Study Questionnaire). The guide for individualizing services considers such aspects as decentralization of decision making, staff roles in an interdisciplinary team, and the new role of management. Among four appendixes are suggestions for behavioral science consultants at children's residential centers. (CL)

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FACILITATION OF KNOWLEDGE UTILIZATION BY INSTITUTIONS FOR CHILD DEVELOPMENT

Final Report to
Office of Child Development
Department of Health, Education, and Welfare

Project Grant No. OCD-CB-103

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FACILITATION OF KNOWLEDGE UTILIZATION BY INSTITUTIONS FOR CHILD DEVELOPMENT

Final Report to
Office of Child Development
Department of Health, Education and Welfare

Project Grant No. OCD-CB-103

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October, 1974

Section A

Project Purposes, Activities, and Evaluation of Outcomes

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"What the Consultant Thought He Was Trying to Do at the Children's Treatment Unit, Southside State Hospital"

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"What the Consultant Thought He Was Trying to Do at Valleyview Boys Center"

Harvey Ross, PhD

"What the Independent Evaluator Reported, Based Upon His Interviews at [the Four Institutions] in November, 1973, Three Months after Completion of the Consulting Intervention"

Roland Wilhelmy, PhD

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Acknowledgements

Many persons have contributed a great deal to the carry-through of this project.

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The study could not have been conducted in the manner planned without the gracious cooperation of the directors and staffs of the four institutions with which we worked for a year as organizational development consultants. In order to preserve the confidentiality of their comments on the consultation interventions, we regretfully are not able to acknowledge them by name.

The comparison group institutions participated in our conferences, cooperated in taking the tests, and offered valuable counsel. They were: Boys' Republic, Cascadia Juvenile Reception-Diagnostic Center, Devereux Schools in California, Napa State Hospital, Sonoma State Hospital, Yakima Valley School, and Youth Adventures, Inc.

Harold Boverman, M.D., Director of Child Psychiatry, University of Oregon Medical School, has contributed perceptive insights and very valuable counsel from his orientation and experience as a consulting child psychiatrist.

We are especially grateful to Ms. Molly Lewin, HIRI's editorial consultant, who made a major contribution to the writing clarity of both sections (A and B) of the report.

We have had four research assistant-project secretaries during the 3-year life of the study: Ms. Devon Chappell (now Mrs. Howard Busse), Mrs. Lynette Robe, Ms. Dee Gregory, and Mrs. Marian Hunt, who has provided masterful guidance, Good Shepherdessing, and delightful equanimity in the pressureful process of getting out this Final Report.

To all of the above, the HIRI project team offers heartfelt thanks.

Edward M. Glaser

Introduction

The project on which the report is based called for an experimental consultation-intervention in four different child care institutions. Our report on each of these four cases includes stating what the consultants did, what the independent evaluator learned through his interviews with staff about the impact of the consultation, and what some questionnaire data from each institution showed. Comments by the HIRI project director are made where appropriate. The report also presents an analysis of overall results derived from two survey instruments--the Baseline Data Form (BDF) and the Institution Self-Study Questionnaire (ISSQ)--administered to staff at a number of institutions.

Because a report addressing all these topics has to be rather long, some readers may feel it presents "more than they care to know" about the project. For these readers, three briefer chapters may suffice to give an overview: the first chapter, recapitulating the project purposes; the second chapter, an overview of the consultation intervention; and the final chapter, titled "Learnings with Reference to the Research Questions Addressed by this Project."

I. Project Purposes and Activities: Recapitulation

The initial specific goals of the project, which began August 1, 1971, as set forth in the Grant Application, were:

1. To identify major advances in knowledge and exemplary practices bearing upon problems of child development which appeared to be underutilized by most institutions working with children.
2. To explore in depth, through reading and site visits, how well and under what conditions these practices were working out in their particular settings, and what the program staff(s) thought were the essential conditions for their successful application in other settings.
3. To visit a representative sample of institutions that might utilize these seemingly promising advances, find out what these institutions knew about the identified innovations, and what had been done (and not done) about considering them for tryout. (During these site visits, efforts were to be made to ascertain what innovative practices or programs these institutions might have adopted during the previous two years, and how those adoptions came about.)
4. To devise and carry out a demonstration project intended to bring about in at least two institutions serious consideration of an innovative exemplary practice which those institutions had not previously adopted, but which seemed clearly relevant to their mission or program.
5. To study the process and evaluate the results of this attempt to facilitate knowledge utilization by institutions for child development.

In November, 1971, as the outcome of a project conference in Washington, D.C., between Office of Child Development (OCD) staff, Human Interaction Research Institute's (HIRI) project director, and invited consultants, it was decided to shift the focus of the project from the issue of wider utilization of innovative practices to an exploration of the following questions:

1. Under what conditions do institutions consider and implement newly defined programs and practices which may be expected to maximize the likelihood of client rehabilitation or developmental progress?
2. In what ways do institutions that develop seemingly exemplary programs and achieve relatively superior outcomes differ from institutions that offer less effective programs for similar clients?

3. In what ways, in the course of consultation, can the seemingly less effective institutions be helped to become more effective in relation to their own potentialities and treatment objectives for the populations they serve?

The activities during Year 1 bridged this change in orientation, shifting from identification of innovative practices to the preparation for consultation which would strengthen organizational effectiveness in children's residential centers. It was hypothesized that, if an institution developed a climate that encouraged periodic review of its own goals, then evaluated its program effectiveness in relation to those goals, it would be more receptive to open-minded consideration of innovative practices developed elsewhere as well as to home-brewed creative ideas for progressive change and renewal.

This new orientation which grew out of the November 1971 meeting prevailed in the subsequent site visits and shaped the plans for Year 2. Accordingly, the project staff formulated the project goals for Year 2 as follows:

1. To identify significant factors that facilitate or inhibit the effectiveness of various types of child care institutions.

2. To develop and demonstrate intervention strategies (e.g., organization development consultation) that are likely to help child care institutions become more effective and efficient as organizations in providing child care and treatment services.

The intervention procedures developed by the HIRI project team for pursuing the above goals have been:

1. To study and obtain an understanding of the way the institution operates in terms of: (a) managerial functioning; (b) interactions among staff; (c) staff in relation to clients and parents; (d) relations between the institution and community resources.

2. To develop and request the institution to apply data-collection instruments which will yield before-and-after assessment of the institution by top management, operating staff, and (in selected instances) others.

3. To carry on a continuing series of periodic consultation visits--first with top management, subsequently with staff, and (at the discretion of management) perhaps with clients. These consultations should be goal focused.

4. To prepare logs of consultation visits (Activity Reports) for distribution to other team members and for documentation of our Final Report.

5. To maintain contact with other institutions which form a part of our communications network and to involve them as consultants when appropriate.

6. To provide the client institutions with what is available in newly emerging knowledge concerning child treatment and rehabilitation (from literature, from exposure to other institutions, from the consultees themselves) and help them determine the applicability of these innovations to their own situation.

7. To develop and apply such specific consultation strategies as seem appropriate to the problems of the individual institution.

8. To document (through case histories or other appropriate means) the nature of changes made, the factors or conditions which account for the changes, and how and why the above factors or conditions occurred.

9. To write a report (based on the evidence we have accumulated) suggesting ways of facilitating improvement in the operations of child care institutions.

In the first year of the project, HIRI:

1. Reviewed literature relevant to child development in institutional settings.

2. Made site visits to 20 residential child care institutions, focusing on their receptivity to innovation and change and on factors associated with organizational effectiveness.

3. Held a conference in June, 1972, for the purpose of information exchange, attended by HIRI personnel, representatives from 14 institutions and other knowledgeable persons involved in child treatment.

4. Developed a rating form to obtain a baseline effectiveness measure of any given residential child care institution, as perceived by its staff.

5. Selected from among the 14 child care institutions, four to serve as target agencies for our consultation intervention and seven to serve as comparison agencies.

In the second year of the project, HIRI:

1. Administered a rating scale to the staff members of the four experimental and the seven comparison institutions. (The scale subsequently has been refined.)

2. Assigned five consultants to the four experimental agencies. One consultant was assigned to each institution. The fifth consultant worked as a kind of "co-pilot" to the other four, joining each one on site visits and serving as a kind of "consultant to the consultants."

3. Established the major consultation goal for the project in terms of helping the staff in each institution examine its goals, work toward developing a consensus about those goals, and review the institution's program effectiveness in relation to those goals. It has been our hypothesis that a natural byproduct of such effort will be improved organizational performance, including improved treatment of children.

4. Had a meeting on December 11, 1972, with the directors of each of the four agencies in the consultation group (one agency director was unable to attend personally and sent a substitute) and Mr. Martin Gula from OCD who wanted to discuss the potential end-products of our project with project personnel and institution representatives.

5. Summarized the developments in the consultation process in each institution as they appeared after 6 months of work. The HIRI staff also projected results for the end of the second year. The information collected has been organized principally from consultant reports called Activity Reports, written after each site visit. The reports provided a constant flow of information which then was shared by each consultant with the entire project staff. In this process feedback then was given by the project team to each reporting consultant. Frequent team discussions (every 2-3 weeks) maintained direction over the intervention activity and augmented the written interchange feedback mechanism. The team meetings also were summarized in Minutes.

6. Derived, after 6 months of consultation, a number of tentative findings (really hypotheses) regarding the role of consultation in promoting organizational effectiveness in children's residential institutions and the impact of our consultation on the four institutions in our experimental group.

7. Presented our research plan and tentative findings in June, 1973, to a group of child development specialists in Washington, D.C., and to a group at the Child Welfare League in New York City for their comments, questions, critique and suggestions.

In the third year of the project, HIRI:

1. Undertook an orderly and gradual suspension of consultation activity in the four target institutions, but with sufficiently frequent site visits to observe the consequences of our intervention.

2. Undertook an intensive in-depth analysis of the consultation Activity Reports to classify the character of the various modes of intervention, to gather evidence of the impact of the intervention, to document findings and discuss their implications.

3. Commissioned an independent evaluator (Roland Wilhelmy, PhD, University of California at San Diego) to visit each of the four target institutions to systematically adduce information bearing upon changes in each institution or in its operation in the course of the consultation period (August-September 1972 to July 1973), and seek evidence regarding possible relationships between such changes and the HIRI consultation. The independent evaluator, having read the entire file of material pertaining to each of the four institutions that received consultation, also pursued specific questions bearing upon what each consultant reported he had attempted to do or facilitate or help bring about.

4. Worked on the development of the following products:

   a. A Baseline Data Form, revised and now entitled Institution Self-Study Questionnaire (ISSQ) (see Appendix B). This assessment instrument was designed to be useful for a child care institution to learn how its staff perceived the particular institution's functioning at a given point in time with reference to various types of practices and modus operandi that have consensus support in the child development literature... and which could be used for periodic self-study evaluation.

   b. A Compendium of Innovative Practices, which records non-standard practices that seem to work particularly well as reported or observed at 14 institutions during HIRI's site visits in the first year of this project (see Appendix C).

   c. A report (Section B of our Final Report) entitled "Organizing a Children's Residential Center to Provide Individualized Services," with an appendix directed to organizational consultants. This product also will address the stated project goals.

   d. A final overall project report.

II. Overview of the Consultation Intervention

☐ Consultation for What--and How?

Although each of the consultants employed his own individual strategies in working with the particular institution assigned to him, they agreed that they should strive toward common goals: The major consultation objective was to help each institution become more effective in terms of the mission the institution staff had affirmed in connection with providing services to clients. To attain this goal, the consultants agreed to encourage institutional staffs to examine the effectiveness of their programs and processes (including interpersonal relations) for goal attainment, develop a consensus about those goals, try to improve their processes, and evaluate outcomes. We assumed that, in the course of doing so, an institution's staff would increase its capacity to differentiate its objectives, to develop programs which would better reflect those objectives and to work to implement those programs in all levels of the institution, especially at the child care level. Thus, the ongoing treatment of children and the results of that treatment would be brought into clear focus.

Consultation visits began in August, 1972, and continued at intervals mutually agreed upon by the consultants and institutional staffs until July 31, 1973. Each of the four consultants was budgeted 60 days for his total efforts in Year 2 of this project. Since the consultants also were expected to participate in weekly or bi-weekly project team meetings and to write a report covering each consulting day (Activity Report), the 60-day allotment permitted up to 40 days of direct consultation activity. The Activity Report covering each consulting day was circulated to each of the other consultants for information, invited comment, question, or critique. These circulated Activity Reports were then sent back to the authors. In this way, as well as at the team meetings, all the professional personnel on the project became consultants to each other. Sample Activity Reports can be found at the end of the writeup regarding the consultation intervention at each of the four institutions in the experimental group.

In addition to the site visits by the consultants to each institution in the experimental group, two other "stimulus inputs" were provided by the HIRI project: (1) Modest funds were made available to the experimental group which might facilitate visits to other child care institutions with reportedly unusual programs or some other exemplary practices or treatment outcomes. (2) Each of the four institutions was offered a (free) special 1-day workshop by a member of the project team from the Pennsylvania State University College of Medicine (Dr. Peter Houts and Mr. Robert Scott) on ways of developing individualized goal planning for each child.

By design, the four institutions were chosen to represent a stratified sample. We selected these four from the available nine that invited the consultation so that they would be considerably dissimilar in terms of their organization, the types of children they served, the severity of their organizational problems and their initial staff receptivity to consultation help. On the one hand, there were institutions with histories of providing individualized services to children which had developed relatively smooth processes and sophisticated child care technologies. Other institutions, new to the concept of individualized services had not yet developed well integrated or demonstrably effective treatment procedures. This diversity has provided the project with richness of experience; it also has made it somewhat more difficult to abstract general principles we hope to develop from our experience.

The special problems of recording, comparing and analyzing the consultant experience at the four institutions were a major focus of the research effort during the second project year.

☐ Consultation by Whom?

Five consultants were engaged to work at the four institutions. Two are PhD psychologists with extensive backgrounds in clinical and organizational consulting. Two are advanced graduate students with Masters' Degrees who are candidates for the PhD at the UCLA Graduate School of Management. The consulting orientation of these UCLA students is derived from the socio-technical systems approach developed at the Tavistock Institute in England.

Each of the four above consultants was assigned to one of the four target institutions.

Our fifth consultant is an MSW who has had staff experience in child care institutions. We originally recruited her to serve as a resource person mainly for the two systems consultants who had not had experience with residential child care institutions. Her role subsequently expanded and developed. At the beginning of Year 2, she was invited to complement each consultant's competence with her own professional experience and training. She frequently accompanied the other consultants in their institution visits, engaged in consultation activities under each primary consultant's guidance, and reported the site visit fron her independent perspective. As she became acquainted with each consultant's activities and the characteristics of the institutions, she accomplished a cross pollination of ideas that facilitated interconsultant communication. Later, as the project grappled with the problem of making comparative analyses of the four consultation experiences, it appeared that the fifth consultant's participation in the consultation at all four institutions had made her a useful resource for certain types of analyses.

☐ Evaluation: Assessing Consultation Impact

Evidence of "improvement" (if any) would be sought from: (1) the consultants' Activity Reports, module records and documented changes that clearly could be traced to the consultant intervention at the institutions; (2) reports from the staff at each institution, elicited through post-consultation site visits by an independent evaluator; (3) relevant outsiders' (such as members of the board of directors) opinions and perhaps residents' impressions and accounts, where obtainable; (4) comparison of scores obtained at each institution (in both the experimental intervention group and in the comparison group which did not receive consultation) on the Baseline Data Form administered at the start of consultation in 1972, with scores on the Institution Self-Study Questionnaire (40 items on the two questionnaires were the same) administered shortly after termination of the consultation.

It should be noted that a HIRI orientation with regard to program evaluation in general, and this evaluation problem in particular, is that the seeming exactitude of questionnaire response measurements taken before and after an intervention... tend to leave a residuum of obscurity; therefore the need for additional kinds of evaluation evidence.

Many factors can confound the interpretation of comparative test score results. Suppose, for example, that the initial or pretest set of many of the respondents includes some suspiciousness about whether a completely frank response could get the individual in trouble with "the powers that be" in his institution--that an answer sheet might be traced back to the respondent because the minimum identifying information included a check-off of sex, age, and whether the respondent was on the treatment staff or the support services staff. If such a set prevailed among an appreciable number of respondents, their answers to the pretest questionnaire items might tend toward the favorable, or at least not-too-critical side of the scale. Then, suppose actual experience during the ensuing year indicated no risk whatever for negative evaluation; only a positive effort at the institution to follow problem identification with problem solving. And suppose further that the consultation process in a given institution resulted in establishing a climate wherein self-challenge and auto-criticism now received positive reinforcement. In that case, the set for responding to the post-consultation questionnaire could be appreciably more critical in stance than at the time of the preconsultation administration.

Thus, what is "good" and what is "bad" in pre-post score comparisons is obscure, and HIRI's evaluation orientation therefore is to place major credence on documented clinical data, or on verifiable critical incidents and reports from persons involved or affected: in effect, to place more credence on cumulative and convergent evidence of the senses, plus explicitly reasoned interpretation thereof, than on test score comparisons. The main value of our ISSQ instrument as we see it and as the experimental and comparison group institutions have used it, is to afford a systematic means for staff identification of problems and opportunities--for institutional self-challenge--and have this serve as a springboard for constructive organization development or renewal.

The personal interview questions posed by the independent evaluator (Dr. Roland Wilhelmy) as he visited in October-December, 1973, with individual staff members and sometimes staff groups of the four institutions which received HIRI consultation were:

1. Think back to August 1972. Would you tell me all of the changes, and all of the significant events that have happened here since then? (Organizational, procedural, staffing, meetings) (Read back my recorded notes of the person's list for corrections, additions, and approval.)

2. Would you tell me how you think these changes came about? Let's start with ______________. (Present all promising items. Try for recall, then recognition.)

3. (Asked only if not already answered by response to question #1) What came of (the event)? Were there any results? Has it changed the way things are now? (Try to get recognition of specific interventions not mentioned before.)

4. Which of those changes do you think was the most important, or the most useful; which was the least important, or the least useful?

5. Using a scale where a score of 100 would be an absolutely perfect situation and zero would indicate a disastrous failure, would you tell me how you would rate the general situation here now? What would you rate the way it was in August 1972 (or date the person first started to work here, if a later date)?

6. Can you tell me some things that ______________ (the HIRI consultant) might have done here, or done differently? Can you tell me some things that ______________ (the given institution) should have done differently with ______________ (the HIRI consultant)? What is the best thing that ______________ (the institution) and ______________ (the HIRI consultant) accomplished? (Ask this in case the most important thing in question #4 wasn't a HIRI intervention.)

7. Assuming that ______________ (given institution's) essential needs were met and you had some discretionary funds, what are some of the things you would use them for? Do you think that ______________ (this institution) is better able to exploit the services of a consultant now than it was before? Why? If you could get a consultant on a basis similar to that with ______________ (the HIRI consultant), would you want one now?

8. Events: Questions pertaining to particular events and consultation interventions reported by the HIRI consultant, if comment on these did not arise from the interviewee in response to the preceding seven lines of inquiry.

The overall purpose of the various convergent evaluation procedures has been to obtain evidence regarding two factors: (1) Internal validity--did in fact the experimental interventions make a difference (did they have demonstrable impact in relation to their purposes) in each institution and in the group of four that received the consultation intervention? (2) External validity--to what populations, settings, treatment variables and measurement variables can this effect be generalized--what can be learned from this study that might be of generalizable value?

* * *

The next chapter of this report, which begins on the following page, deals with the consultation intervention at the four institutions which comprised the experimental group. We would have preferred to use the real names of the institutions, partly to give them open credit for their cooperation, and in most cases, for their excellent achievements. However, considerations with regard to preserving confidentiality, or safeguarding what might be regarded by some persons as professional communications bearing upon individuals, made it advisable to invent fictitious names of institutions and anonymous designations for individuals.

The report bearing upon each of the four institutions was submitted to the present director in each instance, and has been cleared by that person for publication.

III. Description and Evaluation of the Consultation and Its Impact on the Four Target Institutions

LAKECREST CHILDREN'S HOME (LCCH)

A. Summary Description of the Institution

The Lakecrest Children's Home has been in operation since 1889. Its focus has changed through the years from the care of neglected children at its inception to its present mission of the care and treatment of emotionally disturbed children. The home is a nonprofit, nonsectarian organization, licensed by the State Department of Mental Hygiene and operated by the Lakecrest Children's Home Association. It is governed by a board of trustees consisting of 21 members. The annual budget for the agency is approximately $1,166,000.

The agency provides residential care for boys and girls aged 6 to 11, group home (community treatment) care for boys aged 12 to 15 and girls aged 12 to 17. It serves a population of approximately 45 children who are referred by such agencies as the Welfare Department and the Probation Department, by relatives, private psychiatrists, school personnel, child guidance clinics, etc.

The treatment operation is based on the team concept, with unit supervisors, unit coordinators, child development counselors and social workers as members of the team. An ongrounds school is available to children who are unable to adjust to a public school setting and the teachers and tutors are also part of the team. The organization of the home's staff is detailed in Table 1.

B. What the Consultant Thought He Was Trying To Do at LCCH

(The following statement of objectives, perceptions and strategies of consultation was prepared by the HIRI consultant to this particular institution, Robert Blinkenberg, M.S., M.B.A., and candidate for PhD in the Graduate School of Management, UCLA.)

1. Overview

During the period of consultation, the population typically ranged between 40 and 50 children in care, with a stable pattern averaging about 44 children.

Table 1: Organization Chart, Lakecrest Children's Home

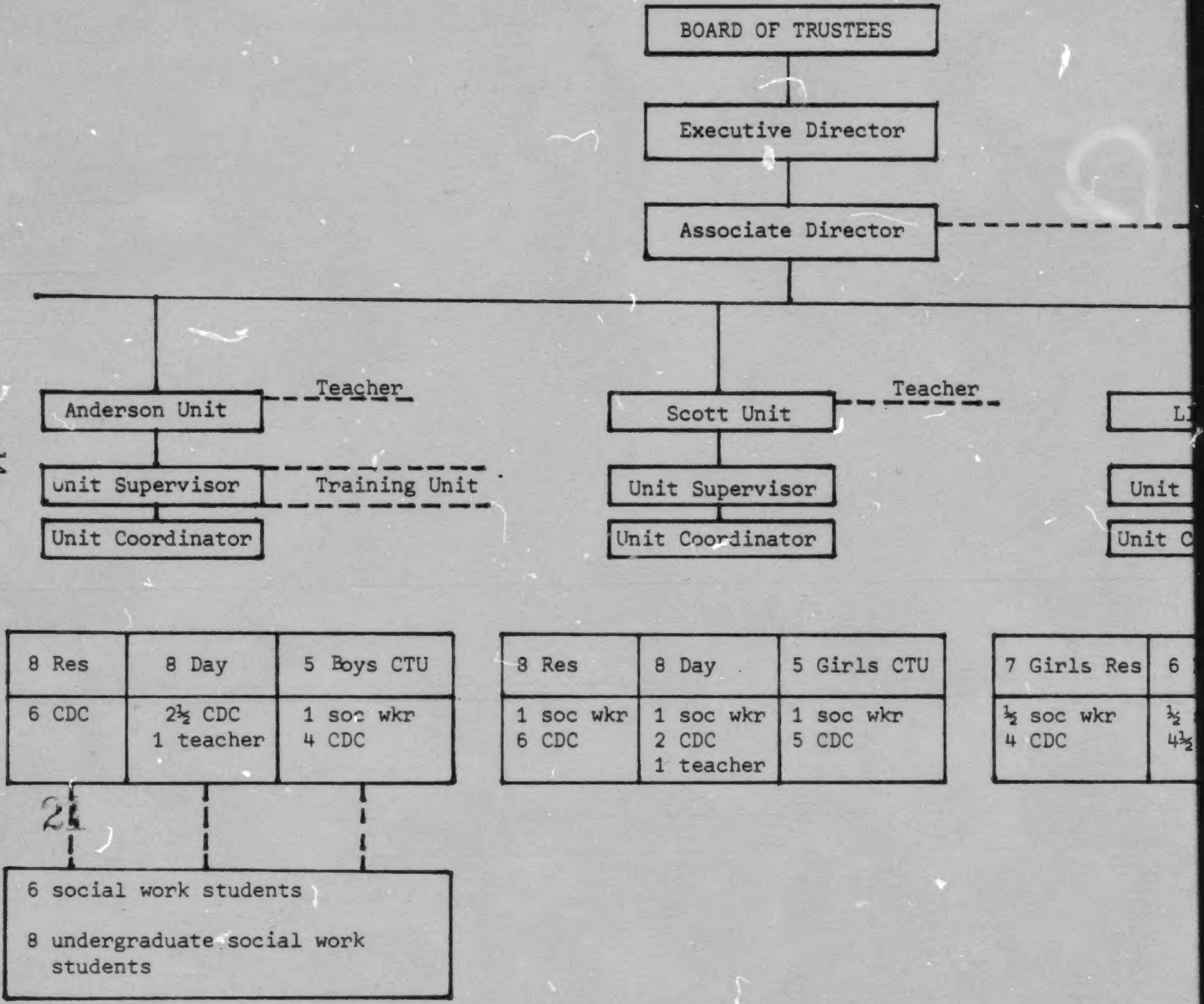
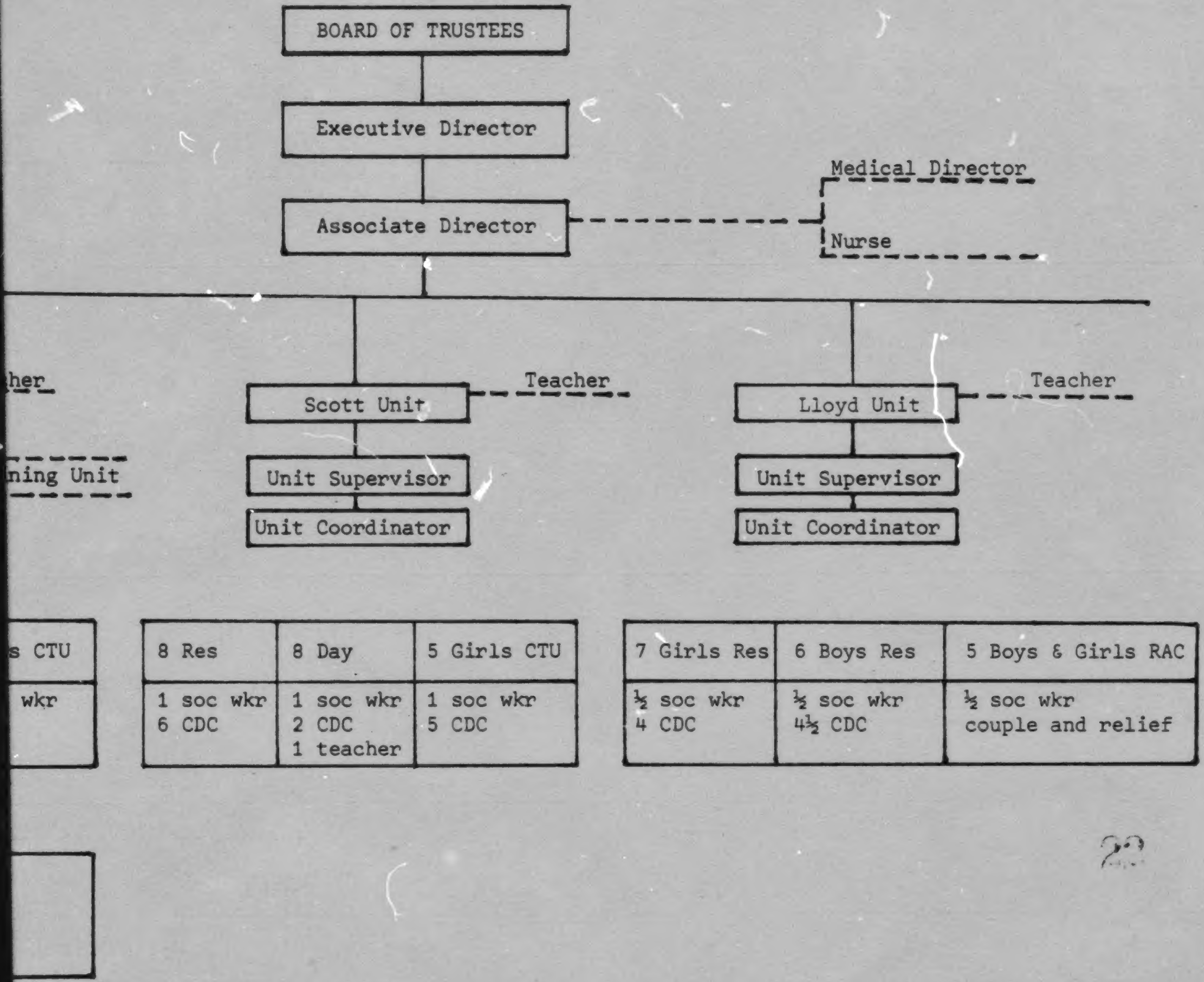

BOARD OF TRUSTEES
Executive Director
Associate Director
Anderson Unit
Teacher
Unit Supervisor
Training Unit
Unit Coordinator
Scott Unit
Teacher
Unit Supervisor
Unit Coordinator
Unit
Unit C
8 Res
6 CDC
8 Day
2½ CDC
1 teacher
5 Boys CTU
1 soc wkr
4 CDC
8 Res
1 soc wkr
6 CDC
8 Day
1 soc wkr
2 CDC
1 teacher
5 Girls CTU
1 soc wkr
5 CDC
7 Girls Res
½ soc wkr
4 CDC
6
½
4½
6 social work students
8 undergraduate social work students

Table 1: Organization Chart, Lakecrest Children's Home


BOARD OF TRUSTEES
Executive Director
Associate Director
Medical Director
Nurse
her
ning Unit
Scott Unit
Teacher
Unit Supervisor
Unit Coordinator
Lloyd Unit
Teacher
Unit Supervisor
Unit Coordinator
s CTU
wkr
8 Res
1 soc wkr
6 CDC
8 Day
1 soc wkr
2 CDC
1 teacher
5 Girls CTU
1 soc wkr
5 CDC
7 Girls Res
½ soc wkr
4 CDC
6 Boys Res
½ soc wkr
4½ CDC
5 Boys & Girls RAC
½ soc wkr
couple and relief

The agency was under the direction of an executive director who reported to the board of trustees. An associate executive director supervised the three unit supervisors. The three unit coordinators were staff to the unit supervisors. There were also a medical director and staff psychiatrist to aid the treatment teams. An intake coordinator helped screen children for the agency. (See Table 1: Organization Chart, LCCH)

The staff was composed primarily of younger people, ranging in age from early twenties to early thirties. Certain senior positions, such as that of executive director, were filled with older individuals.

The organization was basically a unit system with three physically separated units on grounds. They also had an associated day care program.

The administrative building (also separate) housed the general administration as well as various support services (e.g., clerical, intake, financial).

The agency received most of its funding from Short Doyle Mental Health funds, via County Community Mental Health, and CHAMPUS, a military dependents' plan. There were also sizable contributions from United Community Service.

Direct assistance took the form of:

a. Study and diagnosis to determine appropriate service and to develop an individual treatment plan for each child and his family.

b. Implementation of treatment plans in the required services by teams using a combination of such modalities as individual, group, family and play therapy, marital counseling, special education, therapeutic recreational programs and various activities involving families in the treatment program. Residential treatment also included the provision of remedial and ongoing medical care as well as the essentials of daily living.

c. Post-placement services during readjustment period.

The agency operated in accord with the following principles:

a. The agency will interject the least amount of intervention into client-family social systems consonant with bringing about the desired changes.

b. The agency seeks the maximum involvement possible by the client/family in the treatment planning process.

c. The agency focuses mainly on providing help to families to improve their social functioning.

In general, the agency, at the outset of consultation, seemed to be running smoothly with a well qualified and productive staff. The organization as a whole seemed healthy and free of overt symptoms indicating any significant dysfunction. There was low turnover, compensation was above average for the profession, absenteeism was low, there was little counterproductive behavior, employees seemed to identify with the organization, social integration was moderately high, and the agency seemed adaptable.

The agency appeared, however, to be on a plateau of proficiency. The only characteristic that gave rise to any comment was the significantly higher cost of the care provided by the agency relative to other agencies in the community (with staff compensation, at 80% of costs, accounting for the difference). This was interpreted as partial explanation for the lack of other signs of dissatisfaction or alienation.

2. Intervention Strategy

My approach to facilitating improvements in organization effectiveness was to assist the total organization in its efforts to realize its own potential. My strategy was to commit my resources to the growth of the organization.

Consultation was based on the belief that an organization is a learning, developing system. This approach assumes that organizations are capable of utilizing outside resources to effect immediate internal operating improvements as well as to effect long-term improvements in their capability to cope with and adapt to a changing environment.

The approach included:

a. Developing a useful planning perspective: (1) assisting the organization in allocating the planning responsibilities among the board of trustees, the executive director, and the rest of the staff; (2) helping each responsible party to structure his planning process to take account of his objectives and to achieve effective policy.

b. Reviewing the organization structure, processes, and job designs: assisting the administrative staff in determining how best to organize to support the delivery of effective treatment (e.g., continuing their unit/team operation or moving to a service-oriented organization).

c. Promoting a better understanding of effective practices in supervising: (1) working with the executive director in making his style more effective, (2) working with new supervisors to develop constructive alternative approaches to their new tasks.

d. Helping the organization to build within itself the ability to effect planned change: working with the agency to develop a viable substructure of staff members who accept responsibility for developing and coordinating the use of special resources to stimulate the agency and offer opportunities for growth and development.

3. Intervention Plan

The planned intervention consisted of five phases:

- Observation and analysis (diagnosis)
- Assessment
- Planning
- Action
- Evaluation

The observation and analysis were designed to determine the current status of the institution, how it was functioning, how well it was functioning, what operational or organizational problems existed, etc. The diagnosis was accomplished by observation, role analyses, interviewing, etc. The data from this phase, plus the results of the assessment, were used in the planning phase.

The assessment was based on a self-evaluation designed to indicate the staff's opinion of where the institution was, operationally and organizationally. (See Appendix 3 for Organization Design Worksheet.) It utilized a baseline data questionnaire to provide a pre-intervention measure of the health of the institution.

The planning phase was designed to determine:

- Which organizational characteristics or trends were perceived as problems by the staff, and (as identified in our diagnosis and assessment phases)
- Which of these we could agree to work on with them

The primary objective of this phase was to negotiate working "contracts" with the institution. It is here that the goals were initially set, priorities determined and decisions made about resource allocation.

The action phase began once the "contracts" were negotiated. In the action phase the consultant worked with the staff in a collaborative manner to bring about improvements in the effectiveness and efficiency of the agency. (The action phase also devoted some time to planning for the future to insure that improvements accomplished as a result of the interventions could be stabilized. There were efforts to build into the institution more of an ability to look at itself and chart its own course of improvement.)

The final phase of evaluation was designed to assess the consequences, impact, and effectiveness of the intervention. This phase was scheduled to be completed in the subsequent project year.

This report provides summary or exemplary descriptions of the consulting activity which occurred in each phase of the consultation at this institution.

a. Diagnosis

The diagnosis was carried out using passive observation, role analyses, interviewing, and participant observation. The following comments represent the results of our diagnosis.

While we did not have the figures available for a reliable comparison, it was believed by many at the agency that the cost of care was at a level near the top of the comparative scale. It had also been said that this cost of care ran parallel to their quality of care. That is, they viewed themselves as providing high quality and correspondingly expensive care.

Lakecrest Children's Home Association, like many other child care institutions, had gone to the unit system. Many of the staff mentioned the trend toward interunit competition of a mixed character.

The agency was expanding its services in many directions: (1) the treatment focus was widening; (2) phasing was being considered in planning for residential aftercare and thinking about preventative community treatment; (3) geographical expansion was being promoted; (4) consideration was being given to widening the age limits of the children; etc.

At the agency physical separation among the units and from the administrative building contributed to communication problems. Interunit communication was not emphasized.

LCCH's "role descriptions" tended to describe collections of tasks and activities and specify functional relationships rather than being related directly to the organization's basic purpose.

The organization was feeling new pressures to demonstrate its equal economic opportunity stance through an affirmative action program. Their thrust was to achieve parity on all organizational levels.

Some of their decision making was inappropriately assigned and had occasionally lagged.

Their support operation tended to be reactive, that is, it primarily responded to requests. This situation tended to prevent planning for greater productivity and effectiveness of the departments.

Their performance appraisal system seemed to focus on the past, and did not include goal setting.

Their reporting relationships did not seem clearly specified. Again the trade-off was one of individual autonomy versus clearly defined responsibility.

The career ladder design was questionable. The role descriptions for some of the more senior positions needed to be reviewed for their required (or desired) qualifications.

These and other findings were used in the planning phase to help allocate the consultation resources.

b. Assessment

The assessment was accomplished using the Baseline Data Form (BDF), an 80-question evaluation instrument used to survey staff attitudes. Included here, as an example, is one finding deemed significant for LCCH.

The comparison between the responses of the administrative staff and the program staff indicated a difference in the opinion between these two staffs with regard to how well they thought the Home was operating. It seemed that at the Lakecrest Children's Home the program staff was more content, more satisfied with the way things were going and the rates of change than was the administrative staff.

In an attempt to explore and validate this assessment we shared these data with the staff. Their reactions, while intended to explain the response pattern, also provided us with many foci for our later consultation efforts:

(1) Administrative staff's more complete knowledge of agency programs, operations, etc.

(2) Administrative staff's norms of openness and candor.

(3) The problem-oriented appreciative set of the social welfare professional.

(4) The weakness of communications with the executive director.

(5) The inconsistent levels of responsibility and authority of the administrative staff.

(6) Impending staff changes (resignation of two key staff) and their cascading effects.

(7) Vagueness of the unit coordinator's role.

c. Planning

The planning phase was designed to identify problem areas or opportunities that we could agree to work on with the staff.

We used the data from our diagnosis as well as the data derived from discussion of the results of the application of the BDF to identify problem areas or opportunities.

Our effort to establish working relationships--by setting individual and group "contracts"--was carried out primarily in a series of meetings with cross section groups of staff. We discussed, clarified and illustrated what we meant by our comments and continually asked if there were any areas in which the staff wanted to work with us.

As a result of these meetings and other elements of our association, we set several collaborative contracts. These are described as follows:

(1) A contract with the director to evaluate an outside research proposal.

(2) A contract with the director to engage with the board of trustees to accomplish successful redesign of the board operation.

(3) A contract with a unit supervisor and his program committee regarding staff development and training.

(4) A contract with the administrative staff to redesign the organization structure and operation.

(5) A contract with the program staff to improve the inter-personal relationships among themselves and with the children.

These last four contracts are described in the next section.

These contracts were often updated and others were added as the consultation progressed, but the above are representative.

d. Action Phase

In the consultation activity with this agency there were two kinds of elements to the pattern of the intervention relationship. The first of these was a discrete, fairly self-contained event. This kind of element was typified by workshops such as one on responsibility negotiations and allocation; and exercises, such as one on self-disclosure and one with the board of trustees. These are one-time experiences.

The second kind of element was more of a process--an open-ended, continuing subrelationship. These subrelationships have had their foci but have been extensive rather than intensive experiences. Examples of this kind of element are: (1) the work on staff development and training, and (2) the work during the planning phase on helping the agency improve its ability to use outside resources.

It should be noted that there is definite interdependency between the two types of elements--neither can, nor does, stand alone. The agency executive director has aptly described this situation as an ongoing overall process with discernible highlights. What follows then are descriptions of some of the elements of the consultation activity, which, when taken together, form the integrated relationship.

The action phase began with a series of personal contracts with various individuals on the staff. These contracts typically concerned personal style. These contracts will be termed preliminary because they typically led into further work. While they proved useful in the personal sense for the staff member, they were preliminary to the subsequent, major undertakings of the consultation. Three such contracts pertaining to individual style and effectiveness were effected. One was with the director and two were with unit supervisors.

In one case (unit supervisor #3) this contract did not directly lead into any further contract. In both other cases, new, parallel contracts were established. For the director I reviewed and evaluated an outside research proposal. In this case I assumed the role of expert (as opposed to resource person). With the other unit supervisor I contracted to help him design and plan a staff development program.

These five preliminary contracts (and one occurring later in the consultation) were the ones that got the consultation started. In no case did any central contract arise without being preceded by a preliminary contract. The central contracts pursued two themes. The first theme was the organization and administration of the children's residential center.

Major effort related to the first theme was expended in three areas: (1) organizing the board of trustees; (2) learning how to utilize a consultant; and (3) organizing the administrative staff. A minor effort was also made in the area of designing a management audit system for the board to use in evaluating the agency's performance. This contract remains open as one of their several continuing efforts.

The second theme was supported by four central contracts: (1) implementing a staff development and training program; (2) improving their use of goal planning; (3) learning how to be more self-disclosing; and (4) improving the treatment team operation.

As noted earlier, there were several continuing efforts. My involvement in these efforts has terminated, but progress continues. These include: (1) board of trustees management audit system; (2) allocating administrative and program responsibilities; (3) utilizing goal planning; and (4) improving the treatment team operation.

These continuing efforts obviously cannot be evaluated as accurately or completely as those efforts that had concluded before the end of the consultation period. All of them, however, can, it is hoped, be evaluated by the end of our project.

e. Preliminary Evaluation

In my judgment, the proximal outcomes of our major interventions were as follows:

Board of Trustees: A major redesign effort had been initiated at the close of consultation. While the implementation was not concluded, it seemed that progress was being made in linking the board more closely to the children's residential center (CRC) and in meeting the CRC's needs for support and guidance.

Utilization of Outside Resources: On several occasions the CRC sought, developed and utilized outside resources. The CRC also became more capable of managing these resources to its own best ends.

Staff Development and Training: An extensive development and training program was implemented. This involved the utilization of outside resources referred to above.

Responsibility Allocation: The staff carried through an allocation program to assign responsibilities and is on its way to specifying detailed evaluation criteria and parallel accountability structures.

Goal Planning: Explicit goal statements are beginning to appear in the treatment plans. The psychiatric review form has been modified to emphasize goal planning.

Self-Disclosure: Every subunit team held meetings to discuss the concept of self-disclosure and suggest ways of promoting it. Many staff members exhibited a startled awakening concerning the concept and found the lack of self-disclosure had been distinctly dysfunctional.

Team Treatment: All unit teams exhibited in their treatment meetings and in their treatment plans a heightened awareness of the importance of team treatment. Two subunit teams held continued discussions to explore the bases and implications of team operations.

(A sample of the consultant's Activity Reports, written after each consultation visit, is appended at the end of this portion of the report.)

C. What the Independent Evaluator Reported, Based Upon His Interviews at LCCH in January, 1974, Six Months after Completion of the Consulting Intervention

(This report was submitted by Roland Wilhelmy, PhD, the independent evaluator.)

1. Assignment

To meet with certain staff members of Lakecrest Children's Home and to assess and report the changes that had taken place there since August, 1972. The prime focus of my investigation was the impact that HIRI's consultants' actions had had, but I was also interested in all significant changes, regardless of how they came about.

2. Procedure

Because of scheduling constraints, my visit to LCCH covered parts of four consecutive days. I conducted a series of interviews with members of the agency staff. The interviews lasted between 1 and 1-1/2 hours each, with the exception of a brief interview with a teacher. They were conducted in the individual's or group's place of work. Each interview began with three open-ended questions asking the respondents to help the interviewer list the significant events or changes, describe what led up to them and what they, in turn, might have led to. Three subsequent questions asked the respondents to state which change seemed most important, to rate the current situation and the situation in August, 1972 on a 100-point scale, and to describe ways in which the client-consultant interaction might have been strengthened. In addition to the questions just described, I had a checklist of items which, on an a priori basis, seemed to be important to investigate.

In separate interviews, I met with two trustees, the executive director, the associate executive director, three unit supervisors, five social workers, the intake coordinator and two unit coordinators.

I met with the school psychiatrist and a number of the child care workers in informal situations when I sat in on psychiatric review meetings of the girls' community treatment unit and the Lloyd residential unit. My purpose in observing psychiatric review meetings was to form an impression of the function of treatment teams at LCCH.

3. The Interviews

I stayed fairly close to the questions listed on the first page of my interview sheet, asking questions when necessary and noting which answers I didn't have to ask for. The interviews generally seemed quite good--people were willing to talk. In fact, many of them seemed to appreciate the chance to recollect their impressions of the period of consultation and the changes that had ensued from it.

a. The First Three Questions (these questions are listed in Chapter II, Overview of the Consultation Intervention)

b. Major Events to Which I Hoped to Evoke Staff Response

Before visiting LCCH but after reading all of the consultant's reports, and after meeting for several days with Harvey Ross, Jean Hall, Molly Lewin and the consultant, I had prepared a list of events and major consultant interventions, which it seemed LCCH staff should be able to recall in some detail. The events were:

(1) A reorganizing and restructuring of the board of trustees.

(2) Improving the organization of the administrative staff.

(3) Working with the staff development and training committee (hereinafter referred to as the SDTC).

(4) Working on responsibility allocation negotiations.

(5) Improving treatment team operation in the girls' community treatment unit and the Lloyd Unit.

(6) Designing a management audit for the board chairman.

(7) Consulting on personal style of the executive director, and working with him on an outside proposal by a management graduate student who wanted to do a study of LCCH.

(8) Learning how to gain maximum benefit in using a consultant.

These events are described in detail in the consultant's narrative account of his efforts at LCCH.

c. Interview with the Executive Director--Important Events Recalled

The executive director felt that LCCH "could get too... comfortable." He said that LCCH has had 16 years of growth and he doesn't want it to stop now.

The executive director has learned to trust people. His trust developed gradually during the consultation period. Along with it he evolved a "wait and see" approach. He thinks the staff now feels comfortable in telling him when he is treading on private waters. He pointed to two possible sources of this change. One was the consultant. The other was the change in staffing of the associate director position. The previous associate director had been brilliant but unable to communicate well with the other staff. The present associate director relates better and uses "process" in developing plans. During the tenure of the former associate director, there had been considerable divisiveness. During this time also, the staff had been testing a lot of different ideas. They developed ideas, but weren't capable of carrying them through. With the new associate director and with the consultant's assistance, they have been able to bring some ideas into fruition.

In the past year there have been more external forces at work on LCCH than ever before. These included confusion at the state level dealing with licensing and regulations and drastic changes at the national level with CHAMPUS withdrawing or threatening to withdraw funding for dependent children. These forces have led to the realization that LCCH needed to look at itself internally. As a result, they have adopted management-by-objectives (MBO) at numerous levels in their organization. In the treatment team meetings, MBO is particularly effective. They didn't know what MBO was before the outside consultant's presentation (goal planning workshop made available by the HIRI consultation to each of the four agencies). Now they are even trying it in fund-raising efforts through their newsletter.

The negotiation of roles and responsibilities is not really completed yet. He said they went through the processes of negotiation, but the results are not yet down on paper. The exercise has made them think and later even rethink about tasks.

The director wants to have some input on hiring and firing. He talked about efforts to involve the board more in the activities of LCCH but he also emphasized the external forces working against active management decisions by the board of trustees. For example, how is it possible to get board involvement in the development of grant proposals when they are only given nine days in which to apply? With such time constraints it is difficult enough just keeping the board informed of preceding events. The board reviews the decisions made and acts as a kind of rubber stamp. He felt that there is a myth of major decision-making abilities by the board of trustees. He feels that all the children's residential centers are copping out in their underutilization of boards.

A new matrix structure of committees of the board of trustees had been established during the time of the consultation. However, certain difficulties with that structure became apparent as time went on. Very recently the structure was revised following suggestions from a unit supervisor. The difficulties with the former committee structure were apparent to all, and modification was readily accepted. The new matrix made it easier for staff to participate in the committees of the board because the staff only needed to meet with the members of one committee. In addition, it allowed board members to become more knowledgeable about specific units than they had before.

The executive director felt that many of the changes were not as perceptible as would seem reasonable. I feel that many of the changes made are subtle, because LCCH was already operating in a satisfactory manner before consultation. Therefore the consultation effects appeared as "fine tuning" rather than a major overhaul of the whole system.

d. Interview with Person A--Important Events Recalled

Person A began his present duties in October, 1972. He felt that one of the most significant changes was clarification of roles and responsibilities. Clarification began with the executive director's and associate director's areas of responsibility and later filtered down to all.

The associate director was given charge of maintenance. This turned out to be quite successful. In the past, maintenance had been a burden on the executive director. Now it was operating more smoothly and satisfactorily.

The HIRI consultant was reported to have cooperated with staff development and training processes. The consultant helped in trimming off the rough edges and "taught them how to utilize process" more. While Person A never really "jelled" with the consultant, he did learn the real value of process, which has made his job much easier. Now "other people do much of the work" for him.

In response to the outside consultant's presentation on individualized goal attainment for each child and a letter from the director of the Department of Mental Health regarding clinical accountability, LCCH has developed its own format of goal planning or management by objectives. While his presentation did not catch on at the time it was given, the delayed response to it has been considerable and worthwhile. Person A made particular use of the consultant's booklet.

He felt that the change in the board committee structure to a matrix system had been for the better. The matrix is two dimensional: service committees overlaid by functional committees. In its latest form it was only one week old at the time of the evaluation interview, but, in Person A's opinion, the change has proven itself already.

There have been many significant staffing changes and changes in the program. Among others, the girls' community treatment unit program has become quite strong, as a result of cooperation between the unit-staff and the consultant. The former weekly administrative staff meetings are now held every other week. In the intervening weeks, program staff meetings are held. This gives nonadministrative staff an opportunity to participate in appropriate planning and to communicate their ideas and needs directly to the administration. The program staff also participate through their work with the trustees' committees.

3. Interview with a Member of the Board of Trustees--Important Events Recalled

The consultant's involvement with the board began as a surprise. The policy review committee of the board met with the consultant. At the meeting, the consultant proposed a "sensitizing exercise." The chairman was concerned as to how the board would take it but he was willing to give it a try. The exercise turned out quite well, to the surprise of the chairman. The response was spontaneously healthy and enthusiastic. The results of the exercise were summarized by the consultant and fed back to all concerned. Then an ad hoc committee picked it up to see what changes, what new structures, might meet the expressed goals and solve the expressed problems.

This ad hoc committee met "forever." After two or three meetings it still wasn't going anywhere. The chairman let it go to see what the board could do. The executive director wanted more committees to deal with the expanded services at LCCH, but the chairman felt that the board didn't need more committees. He felt the board needed more active involvement--needed to become something besides a rubber stamp.

Eventually the chairman proposed a matrix structure for the board where each board member was to serve on at least one of each of two kinds of committees. One committee dealt with functional matters while the other was concerned with information gathering. The matrix structure has not proved out yet, he felt, but there is an increase in the activity of some of the board members. Increased activity by the board has led to the appearance, at least potentially, of a new problem. A substantial increase in knowledge might result in increased participation to the point of meddling.

The consultant also assisted in the preparation for a management audit. The trustees have been acting out of faith rather than knowledge and understanding. The management audit is not yet set up formally, although some parts are fairly complete (for example, appraisal of service). The former president of the board is now the chairman of the audit committee. He's proceeding with due caution because he feels that evaluation of anything but the final end product of the institution might tend to force the institution to deviate from its goal in child care and concentrate instead on apparent internal efficiencies.

f. Interview with Person B--Important Events Recalled

He began in his position in March, 1973, and is not familiar with the preliminary steps taken by the consultant. He felt that the consultant was involved in two major projects: clarification of the roles in the entire agency, and work on communications within the units. Staff of the girls' section of his unit were more involved with clarification and communication than were the boys' staff. Various steps were taken to improve communication, to study the differences among the staff's values and lifestyles and the effects of the staff's values on treatment of the children.

It was his perception that the role clarification and negotiation began with clarification of the responsibilities of the executive and associate directors. From there it went to the intake coordinator, the unit supervisors, and the unit coordinators. At the unit level, at the level of the child development counselor, he felt that there was no negotiation, only clarification. He thought that going through the processes of negotiation and clarification was useful for the participants and that it was most helpful at the level of the unit coordinator and up.

When Person B first began his present duties there was discussion of the treatment of each child only once every 3 months. The discussion had in reality been more of a "gripe session" than a treatment meeting. It was not focused on the child and his treatment. Treatment meetings now take place every 2 weeks. The agendas for these meetings include discussion of the child's treatment and of staff feelings. The child's teachers, social workers, and child development counselors are present. His social worker provides a complete family history, a brief history of early problems at LCCH and a description of the current situation. The psychiatrist gives his report and comments on special problems that may have come up. Then the goals of treatment are revised as necessary, and the roles and responsibilities of each participant are made clear.

Other changes have come through the staff development training committee (SDTC). Families of the children are involved early in family therapy. The unit supervisor has at least one meeting per month with each child's parents even when parents show no particular interest in their children. At times the meetings may be as frequent as two or three times per week. The SDTC has provided them with an occupational therapist who provides in-service training in physical therapy as well as occupational and perceptual therapies.

The program staff meetings involve more line workers than did the administrative staff meetings. He feels that the program staff meetings are not functioning as decision-making groups yet. Partly this may be because there's not yet true representation. All of the social workers are present but only three representatives of the child development counselors are invited; no teachers are present.

g. Interview with Person C--Important Events Recalled

In a move separate from the consultation, this unit supervisor was put in charge of staff development and training. He felt that the consultant helped with this project and that a series of specific changes arose as a result of the programs generated there. For example, there is a new psychiatric review format. There is a new intake procedure which involves the parents earlier in the process and provides much more thorough coverage and examination by those in the units who might actually be concerned with the child's treatment. He felt that the consultant was "a very high-powered guy, a sort of hair shirt" who made Person C more productive.

Although at times the consultant was so demanding that it boggled him, he felt that they had a successful partnership nevertheless.

The negotiations on roles and functions were "fun but the jury (was) still out." He is not completely sure of the long-range effect because there is always a tendency to slide back into old procedures and ways of doing things. Considerable improvement is evidenced on the upper administrative level. In particular, the isolation of that level is reduced. In part, this is because of the change in the associate director but it also is because roles are much clearer.

The reorganized committee structure of the board has been revised again, but it looks good now. The board is much more willing to participate. He is glad to see this because he would rather see the board become active before it is forced to by other circumstances outside the institution. The feelings right now are quite positive.

The HIRI consultant's function in the SDTC was to keep it aimed at getting legtimate feedback from the total staff. This led to concrete actions. He liked the presentation by the goal-planning consultant but didn't use the consultant's style. It did set in motion the processes within the SDTC so that they developed their own modes of goal planning. He felt that this was a very lasting gain. He also thought that the parenting workshop with Dr. Tom Rusk (an outside consultant selected by LCCH) was very constructive. He felt the HIRI consultant's work on self-disclosure did not have much impact.

h. Interview with Person D--Important Events Recalled

He felt that the HIRI consultant's efforts had the effect of an outsider who acted as a stimulus to create useful anxiety and thus an opportunity for a new look. The consultant showed a certain impatience to get results, to get things moving. And this impatience may have inhibited people. The intentions of the consultant and of the administration did not seem clear. On the positive side, the consultant got people to become more task-oriented and work with goals. A lot happened through the SDTC. Program proposals came in from the outside, ideas were collected from the rest of the institution, other people were motivated to present ideas and proposals through the SDTC.

The consultant instilled an attitude of accountability in the institution. The implementation of goal-setting procedures and processes was "a superbenefit." He felt that there was a lot of positive carryover from that presentation.

The HIRI consultant helped the executive director be proactive. He felt that the consultant had had a real impact upon the executive director's functions. Personally, he had acquired a different view of conflict, and he had learned to see conflict and problems as constituting challenges and opportunities for change.

During the initial negotiating sessions, Person D found his role changing. He had been supervising all the staff units and later he negotiated some of the responsibilities and handed them to the unit coordinator and the social worker. He found himself supervising these two people. Now both the unit coordinator and the social worker are taking on supervisorial roles. The negotiations forced him to look at roles. The result of the negotiations was that he could pull back and interfere less with others, who were doing what they were supposed to. He's now involved more with the board of trustees, particularly with the committee work.

He sees the institution falling back into old patterns because there is not enough interest in sharing and learning from one another, and in cooperating. He felt that the division of the administrative staff meetings into program staff and administrative staff meetings was productive. He feels that now the administrative staff meetings are less clear than those of the program staff. There no longer seems to be a hidden agenda or politicking outside of the formal meetings, but he does see some lack of openness during administrative meetings.

i. Interviews with the Social Workers--Important Events Recalled

They felt there were a number of important events: the restructuring of the board committee system; the creation of a psychiatric review system which arose through the SDTC; the self-disclosure questionnaire; improvements in the girls' community treatment unit; and the institution of program staff meetings. They felt that the co-consultant was more in tune with social workers and with line staff needs than the other consultant. The SWs' relative insultation from LCCH was discussed with the co-consultant. However, there's been no change in that since then. The bi-weekly program staff meetings came out of the consultation. As yet, the differentiation between administrative staff and program staff areas is not straightened out. Within the units, significant changes have taken place. Social workers are now responsible for treatment plans. In some cases, they use contracts for negotiations of tasks. In other units this is felt not to be necessary. For the most part, negotiations of roles and responsibilities did not affect the SWs. It was left up to the particular unit supervisors to carry out negotiations within the units. In some cases, this was done very extensively but in others as yet there has been little progress in this direction. In-service training has been instituted in perceptual motor therapies. "Every other month" they seem to be having some workshop, e.g., on parenting, crafts, different ideas and new procedures in treatment. Unfortunately there is not a great deal of follow-up on the unit level. As a general principle, they feel that studies and consultations tend to reduce difficulties but that they simultaneously drive certain problems underground.

j. Interview with Unit Coordinators--Important Events Recalled

They feel that coordinators coordinate more with each other now. This came about through a combination of consultant effort and their own needs. They feel that now the staff shares more, which helps to break down imagined barriers. They share more information on children. Unit coordinators see themselves as a link between administration and staff. The consultant helped them in the individual units, particularly in helping them talk to child care staff about policy generated by the administration. They find themselves now in less of a marginal bind than they had been in previously. They felt that the main realization during the consultation was associated with the clarification of roles. Formerly, there had been too much overlapping of roles. Now things tend to be handled more on the unit coordinator level, instead of getting "kicked upstairs."

There has been considerable negotiation of roles within the Scott Unit. They have stayed out of participation in much of the staff development and training programs. They felt that it was a bit foreign to them, but thought it had worked out well for others. There was less utilization of negotiation in Lloyd Unit, perhaps because the supervisor was new. In Scott, first the social worker, the unit supervisor and unit coordinator began negotiations. Later the negotiations expanded to include the whole team. They learned that "you really have to spell things out" but the results are worth it. Information tends to get lost if you don't know who is responsible and who has to be told certain things.

Before consultation began there was considerable restlessness but no ideas for resolving that feeling. Then, during the consultation people began to realize that change could occur. They began to think about possible alternatives. During the time the consultant was present he served as a referee. Now things have been slipping back somewhat.

On an administrative level there tends to be covering up. Things slip by. There is a tendency to ignore problems and to drop things that would have been dealt with while the consultants were here. The program staff and administrative staff meetings still function well.

The negotiations with the consultants have helped people who have come to work since then, because there is now a list of responsibilities available--new personnel practices, descriptions and a checklist of emergency, medical and fire procedures. Many new programs have come out of SDTC.

They felt that the increased pressures from the outside were made more acceptable because the consultant had prepared the staff for them. For example, responses to affirmative action and goal-setting procedures were more constructive, they felt, because their consultant had helped them consider these matters. At the beginning the consultants were threatening because all self-examination is threatening. They thought the consultants would have the answers but soon found out that was not the way it would be.

In Scott Unit there are subunit meetings away from the agency every 3 months. These meetings deal with self-disclosure and other organizational matters. They felt that the administration needs this too, and there must be some way to build it in. They felt that concerning themselves with self-disclosure and world views of the staff involved a lot of difficulties and was quite threatening. On the other hand, the diversity of world views among the staff is useful on a social level with the children. On the treatment level, though, it might become quite confusing.

k. Interview with Person E--Important Events Recalled

She felt that the consultant seemed to resist consulting with social workers. Many changes resulted from the consultant's efforts, however. She and the staff now were involved in intake procedures from the beginning. Intake screening initially begins with the intake coordinator and goes to the psychiatrist, then to the particular placement unit that might be involved with the child. If that unit is unwilling to accept placement, then the child is referred to another unit. Philosophically this was excellent. Formerly parents and the unit staff got together in the beginning, but this involved a lot more work and discussion, making intake decisions a more protracted and slow process. Now there are an endless number of visits. Rejection of the child is more overwhelming for the parents. They do try to suggest alternative institutions.

She felt that the program staff meetings are a significant innovation and permit a better flow of communication. She pointed out that social workers now go on field trips and attend meetings away from LCCH.

l. Interview with Person F--Important Events Recalled

I spoke with Person F because he had been present at LCCH during the consultation but was not involved directly with any of the consultant's efforts. I was interested in seeing what he considered to be significant events and changes during the consultation period. He felt that starting occupational therapy was a focal point, one in which coordinated effort by the teachers and by the unit staff paid off. They were now working more with each individual child. In addition, there were more coeducational activities and sharing. Generally, communications were improved and people from cottages came to school more often as observers and participants.

m. Additional Questions

In addition to the three basic questions (recall of all changes at LCCH since August, 1972, how they came about, and what were the results) which formed the core of the interviews, I directed the following three questions to the interviewees.

(1) Which of those changes do you think was the most important or the most useful?

Executive Director--Most important one-time event was the goal-planning consultant's presentation. He was at the right place at the right time. On a longer-term basis, he felt that the ongoing relation with the consultant was the most important event. He felt the consultant "didn't make it easy" and at times he was a "gadfly"--a "young, impatient M.B.A." But the executive director admired and respected his intelligence and honesty.

Person A--The clarification of roles and responsibilities, where clarification meant that there were agreements and freedom to implement and to receive support in the implementation. This made action possible and the actions allowed other changes at LCCH to come to fruition.

Member of the Board of Trustees--The most significant event was the exercise with the board of directors.

Person B--Most important event was the negotiation between the executive director and associate director. The executive director is now concerned with external matters and the associate director is concerned with programs in the institution.

Person C--The consultant's help with the SDTC was most important because it generated a series of specific changes and set in motion a procedure and a system through which change could continue.

Person D--There were two "most important changes." One was the creation of a goal and task orientation which in turn led to evaluation, procedural changes, and changes in treatment plan. The other was the attempt at unification of overall philosophy.

Social Workers--The social workers are now part of the program staff. Their input is requested and they are no longer the last ones to know about changes.

Unit Coordinators--They felt the role clarifications were most important because they led, in turn, to attitude changes and a more comfortable and trusting basis for communication.

Person E--The change in the intake procedures affected her the most strongly.

(2) Using a scale where a score of 100 would be an absolutely perfect situation and zero would indicate a disastrous failure, (worse than merely closing down), would you tell me how you would rate the general situation here now? What would you rate the way it was in August, 1972?

Now	Then
80	45
85	45
85	85
75	60
80	30
60	40
85	75
80	70
88	78
80	70
87	73
(Mean = 80.5)	(Mean = 61)
N = 11	N = 11

(3) Can you tell me some of the things that the consultant might have done here or done differently? Can you tell me some of the things that LCCH should have done differently with the consultant? What is the best thing that LCCH and the consultant accomplished? (Ask only if question (1) does not give a clear answer related to consultation.)

Executive Director--He liked the way that they got into the consultation, but it scared them. It took two staff meetings following the consultant's first report to get things straightened out. The consultant's impatience was further evidenced in his workshop with the board. The executive director felt the staff was more nearly ready than the board was. There was not enough time for the board to go through the processes necessary for preparation. Also, there was initial involvement but not enough time for follow-up.

Person A--Person A came into his position during the consultation. He had more anxiety than he was willing to admit to a consultant. He found he felt angry because the consultant didn't recognize it. He wished the consultant had been more aggressive in his assistance. In addition, he felt that some of the unit supervisors could have used more assistance on personnel management, hiring and firing, and staff recruitment. He felt that, overall, the consultation was a good experience.

Member of the Board of Trustees--He was not sure what the consultant was about. His aims and purposes were not clear. He wished, at the termination of the consultation, that there had been an opportunity for one-to-one terminal interviews and reports.

Persons B, C, & D--One liked the consultant's direct and warm style and would like him to come back in about a year and give an evaluation. Another would have liked to have had the whole community involved in exercises on communication and self-disclosure. The consultant was a hard-driving guy. At the start people wondered what he was doing here. When challenged on this the consultant did step back and listen. The last person wished the consultant had found a vehicle to work with line staff which was more significant than self-disclosure. An item such as life philosophy would have been better. The other consultant (JH) didn't have much impact. He felt that she had a lot to offer and LCCH did not get it. He had hoped for more openness in management than has developed. In some ways they are back where they started and in others, there is a new understanding. The goal of reduction in unit isolation was not achieved. Negotiations did not lead to improved communication. Special interest blocks still existed and there was lack of a "We're in this together" feeling. The interviewee wished there had been more consultation on management skills or assistance in getting at the administration's communication problems.

Management by objectives was good. Perhaps the consultant took on too much at once. The work with the board of directors came at too late a date. The paper looked good but the result was unsatisfactory. He wished the agency were less quick to pick up ideas without looking at them. There is a tendency to involve others in one's proaction. At times attempting to outguess the needs for proaction generates needless anxiety in others.

Social Workers--Consultant's emphasis was on administration, not treatment. They wish he had spent more time meeting with social workers, but this wasn't structured into the consultant's system. They felt that the work on self-disclosure in the girls' treatment unit was very good. They would have liked him to follow up on it.

Unit Coordinators--They wished that the consultant had been more involved in units and at treatment team meetings. There was some carry over but more would have helped. Since the unit staff hadn't seen the whole process and hadn't been involved in it, they weren't as interested in negotiating.

There was "a mess of a meeting" on finances with no real agenda. Everyone assumed something different about the meeting. They were unsure of the consultant's role. They wished that things had been more spelled out then.

Person E--She wished LCCH had followed through more on the negotiations. For example, the intake coordinator's position is still ambiguous. However, staff development is continuing. The agency has been preoccupied with CHAMPUS funding which has kept it from following up on the consultant's actions as much as it would like.

4. Report of Issues of A Priori Interest

Besides the questions I asked each interviewee, I had a list of items about which I wanted to form an opinion. The items listed below were formulated as questions directed to myself. Sometimes I would be able to answer the questions without asking anyone additional questions; other times I would ask certain questions designed to help me answer my question. Thus, the following are my impressions of the best available "consensus" answers to the following questions:

Does the board make external policy decisions now? It does, to some extent, because of pressures from outside.

Are there different modes of participating as board members? Only insofar as different committees utilize different specialties or different areas of competence.

Is there any change in the executive director-board interaction? No significant immediate changes. The revision of the committee structure may result in different interactions as time goes by.

Did responsibility allocation work out? Did it match with authority? Is accountability suitable for LCCH? Responsibility

47

allocation had worked out fairly well but there is some indication that things may be sliding back to the way they were before consultation. In most cases, responsibility and authority are matched. Deviations from this are noted in this report. It is not yet clear whether the accountability is suitable for LCCH although they seem to be utilizing management-by-objectives with great enthusiasm.

Has LCCH used an organizational consultant since July '73? No. However, the SDTC has instituted a series of presentations dealing with treatment as well as management problems. During the summer most of these presentations dealt with developing skills related to the technology of child care rather than with skills which related to more effective management practices.

Are conscious "contracts" made? "Contract" was the consultant's label for formal agreements--as in Adam Smith's social contract. Contracts are sometimes made between children and child care staff but are not a popular conceptual category at LCCH.

Is there any reunification of personal and professional identity through self-disclosure? Although the work on self-disclosure seemed to be most successful with the girls' community treatment unit, even those others who talked somewhat disparagingly about this work struck me as being quite open in disclosing the nature of their feelings to me.

Are there any changes in goal setting procedures? Very definitely yes. The whole institution is at work using goal setting now, not only in treatment but in management as well.

Have there been any in-service technical training or seminars since last summer? Yes. These are presented by the SDTC on a regular basis. For example, there have been presentations on occupational therapy, parenting, goal setting, crafts, and exercise.

Is the committee to implement goal planning still functioning? The program staff meetings accomplish goal planning now.

Is there any unification of outlook within treatment teams? There is some unification apparent within certain units, and, since child care staff tend to select the units in which they work, on a long-term basis I would expect this tendency to continue. There is no overt plan involved in this unification.

Do individuals know what their own cosmologies are? There is no sign of any great attention being paid to world views or cosmologies on an organized basis.

Are there meetings of the teams when different teams' results are reported? Yes...this can take place in program staff meetings, but I didn't observe any organized structured arena for these presentations.

5. Summary

The composite response of those interviewed was that the consultation had been a constructive and productive experience. The prevailing attitude (at least on the part of management) was not that revolutionary changes had taken place, but that LCCH had been in good shape at the beginning of the consultation and that the consultation process, for the most part, bolstered these strengths.

In many cases, the consultant was explicitly credited with improvements reported. These include the creation of a psychiatric review system; better liaison between management and operational staff; restructuring the board in ways that made it more accessible to the staff; clarification of goals and roles; introduction of management by objectives; generally improved communication; good use of outside resources (particularly the goal-setting demonstration); sharpened focus on each child and his treatment with early involvement of families in family therapy; the emergence of an active and useful Staff Development and Training Committee; and "a stimulus to create useful anxiety and thus an opportunity for a new look." The consultant "set in motion a procedure and a system through which change could continue."

Some slippage was reported in the progress which had been achieved in defining role and function (the target for a specific exercise in negotiation), but the general feeling was that many of the year's gains would hold.

All persons interviewed were asked to rate the general situation at LCCH on a scale of 0-100, as of August, 1972, and again as of the time of the evaluation. The mean score for the earlier data was 61 and for the more recent data, 80.5--a statistically significant difference. These ratings came from a total of 11 respondents.

D. What Is Suggested by the Before-and-After Questionnaire Responses (BDF-ISSQ)

Below, in tabular computer printout form (Table 2) are the responses of the staff at LCCH to the 40 items in the BDF administered in 1972 compared with staff responses to those same items on the ISSQ in 1973. At the end of this listing, are total scores for the LCCH staff on the 1972 BDF compared with the 1973 ISSQ.

TABLE 2

ITEM RESPONSE: FORTY OLD ITEMS AND FORTY NEW ITEMS ON THE I
LAKECREST CHILDREN'S HOME (N=50)

(For old items, ISSO responses are listed first,
and 1972 BDF responses are listed immediately below them)

Response Categories: 1 = Poor; 2 = Fair; 3 = Satisfactory; 4 = Good; 5 =

	RESPONSE CATEGORIES									
	1		2		3		4		5	
ITEM	N	%	N	%	N	%	N	%	N	
1 ISSO	0	0.0	1	2.00	16	32.00	24	48.00	9	18
BDF	0	0.0	3	7.14	12	28.57	24	57.14	3	7
3 ISSO	0	0.0	4	8.00	7	14.00	37	74.00	2	4
BDF	0	0.0	1	2.38	31	73.81	9	21.43	1	2
4 ISSO	0	0.0	4	8.00	31	62.00	13	26.00	2	4
BDF	0	0.0	1	2.38	11	26.19	29	69.05	1	2
5 ISSO	0	0.0	4	8.00	32	64.00	12	24.00	2	4
BDF	0	0.0	1	2.38	28	66.67	12	28.57	1	2
6 ISSO	0	0.0	5	10.00	26	52.00	15	30.00	4	8
BDF	0	0.0	4	9.52	25	59.52	12	28.57	1	2
8 ISSO	0	0.0	4	8.00	26	52.00	17	34.00	3	6
BDF	1	2.38	4	9.52	19	45.24	15	35.71	3	7
13 ISSO	0	0.0	2	4.00	4	8.00	22	44.00	22	44
BDF	0	0.0	4	9.52	8	19.05	15	35.71	15	35
14 ISSO	1	2.00	3	6.00	13	26.00	26	52.00	7	14
BDF	0	0.0	3	7.14	12	28.57	20	47.62	7	16
15 ISSO	1	2.00	5	10.00	22	44.00	18	36.00	4	8
BDF	0	0.0	0	0.0	16	38.10	20	47.62	6	14
16 ISSO	0	0.0	4	8.00	29	58.00	13	26.00	4	8
BDF	0	0.0	3	7.14	12	28.57	22	52.38	5	11
17 ISSO	1	2.00	2	4.00	12	24.00	30	60.00	5	10
BDF	1	2.38	3	7.14	9	21.43	20	47.62	9	21
20 ISSO	0	0.0	3	6.00	1	2.00	31	62.00	15	30
BDF	1	2.38	2	4.76	4	9.52	24	57.14	11	26
22 ISSO	0	0.0	3	6.00	14	28.00	19	38.00	14	28
BDF	0	0.0	3	7.14	11	26.19	21	50.00	7	16
29 ISSO	0	0.0	3	6.00	8	16.00	29	58.00	10	20
BDF	0	0.0	0	0.0	13	30.95	22	52.38	7	16
31 ISSO	1	2.00	9	18.00	25	50.00	10	20.00	5	10
BDF	3	7.14	13	30.95	19	45.24	5	11.90	2	4

50

TABLE 2

EM RESPONSE: FORTY OLD ITEMS AND FORTY NEW ITEMS ON THE ISSO AT
LAKECREST CHILDREN'S HOME (N=50)
(For old items, ISSO responses are listed first,
and 1972 BDF responses are listed immediately below them)

e Categories: 1 = Poor; 2 = Fair; 3 = Satisfactory; 4 = Good; 5 = Excellent

RESPONSE CATEGORIES										MEAN RESPONSE	N
1		2		3		4		5			
N	%	N	%	N	%	N	%	N	%		
0	0.0	1	2.00	16	32.00	24	48.00	9	18.00	3.82	50
0	0.0	3	7.14	12	28.57	24	57.14	3	7.14	3.64	42
0	0.0	4	8.00	7	14.00	37	74.00	2	4.00	3.74	50
0	0.0	1	2.38	31	73.81	9	21.43	1	2.38	3.24	42
0	0.0	4	8.00	31	62.00	13	26.00	2	4.00	3.26	50
0	0.0	1	2.38	11	26.19	29	69.05	1	2.38	3.71	42
0	0.0	4	8.00	32	64.00	12	24.00	2	4.00	3.24	50
0	0.0	1	2.38	28	66.67	12	28.57	1	2.38	3.31	42
0	0.0	5	10.00	26	52.00	15	30.00	4	8.00	3.36	50
0	0.0	4	9.52	25	59.52	12	28.57	1	2.38	3.24	42
0	0.0	4	8.00	26	52.00	17	34.00	3	6.00	3.38	50
1	2.38	4	9.52	19	45.24	15	35.71	3	7.14	3.36	42
0	0.0	2	4.00	4	8.00	22	44.00	22	44.00	4.28	50
0	0.0	4	9.52	8	19.05	15	35.71	15	35.71	3.98	42
1	2.00	3	6.00	13	26.00	26	52.00	7	14.00	3.70	50
0	0.0	3	7.14	12	28.57	20	47.62	7	16.67	3.74	42
1	2.00	5	10.00	22	44.00	18	36.00	4	8.00	3.38	50
0	0.0	0	0.0	16	38.10	20	47.62	6	14.29	3.76	42
0	0.0	4	8.00	29	58.00	13	26.00	4	8.00	3.34	50
0	0.0	3	7.14	12	28.57	22	52.38	5	11.90	3.69	42
1	2.00	2	4.00	12	24.00	30	60.00	5	10.00	3.72	50
1	2.38	3	7.14	9	21.43	20	47.62	9	21.43	3.79	42
0	0.0	3	6.00	1	2.00	31	62.00	15	30.00	4.16	50
1	2.38	2	4.76	4	9.52	24	57.14	11	26.19	4.00	42
0	0.0	3	6.00	14	28.00	19	38.00	14	28.00	3.88	50
0	0.0	3	7.14	11	26.19	21	50.00	7	16.67	3.76	42
0	0.0	3	6.00	8	16.00	29	58.00	10	20.00	3.92	50
0	0.0	0	0.0	13	30.95	22	52.38	7	16.67	3.86	42
1	2.00	9	18.00	25	50.00	10	20.00	5	10.00	3.18	50
3	7.14	13	30.95	19	45.24	5	11.90	2	4.76	2.76	42

		Response Categories									
		1		2		3		4		5	
Item		N	%	N	%	N	%	N	%	N	%
32	ISSO	1	2.00	6	12.00	23	46.00	14	28.00	6	12
	BDF	3	7.14	8	19.05	25	59.52	4	9.52	2	4
33	ISSO	3	6.00	5	10.00	30	60.00	9	18.00	3	6
	BDF	2	4.76	10	23.81	23	54.76	5	11.90	2	4
35	ISSO	0	0.0	2	4.00	13	26.00	28	56.00	7	14
	BDF	1	2.38	1	2.38	10	23.81	24	57.14	6	14
36	ISSO	2	4.00	10	20.00	29	58.00	4	8.00	5	10
	BDF	3	7.14	7	16.67	24	57.14	7	16.67	1	2
42	ISSO	1	2.00	1	2.00	10	20.00	29	58.00	9	18
	BDF	0	0.0	8	19.05	23	54.76	8	19.05	3	7
43	ISSO	6	12.00	11	22.00	27	54.00	5	10.00	1	2
	BDF	11	26.19	15	35.71	12	28.57	4	9.52	0	0
44	ISSO	0	0.0	0	0.0	12	24.00	28	56.00	10	20
	BDF	0	0.0	0	0.0	11	26.19	25	59.52	6	14
45	ISSO	1	2.00	7	14.00	23	46.00	15	30.00	4	8
	BDF	1	2.38	20	47.62	17	40.48	2	4.76	2	4
46	ISSO	0	0.0	5	10.00	13	26.00	25	50.00	7	14
	BDF	0	0.0	2	4.76	3	7.14	24	57.14	13	30
47	ISSO	0	0.0	3	6.00	13	26.00	18	36.00	16	32
	BDF	1	2.38	4	9.52	13	30.95	13	30.95	11	26
48	ISSO	0	0.0	4	8.00	15	30.00	20	40.00	11	22
	BDF	1	2.38	10	23.81	19	45.24	8	19.05	4	9
49	ISSO	2	4.00	3	6.00	17	34.00	19	38.00	9	18
	BDF	4	9.52	7	16.67	11	26.19	17	40.48	3	7
50	ISSO	1	2.00	3	6.00	21	42.00	17	34.00	8	16
	BDF	0	0.0	7	16.67	5	11.90	24	57.14	6	14
53	ISSO	1	2.00	4	8.00	14	28.00	24	48.00	7	14
	BDF	0	0.0	4	9.52	19	45.24	16	38.10	3	7
58	ISSO	1	2.00	0	0.0	10	20.00	33	66.00	6	12
	BDF	1	2.38	3	7.14	9	21.43	23	54.76	6	14

Response Categories											
1		2		3		4		5		Mean Res-ponse	N
N	%	N	%	N	%	N	%	N	%		
1	2.00	6	12.00	23	46.00	14	28.00	6	12.00	3.36	50
3	7.14	8	19.05	25	59.52	4	9.52	2	4.76	2.86	42
3	6.00	5	10.00	30	60.00	9	18.00	3	6.00	3.08	50
2	4.76	10	23.81	23	54.76	5	11.90	2	4.76	2.88	42
0	0.0	2	4.00	13	26.00	28	56.00	7	14.00	3.80	50
1	2.38	1	2.38	10	23.81	24	57.14	6	14.29	3.79	42
2	4.00	10	20.00	29	58.00	4	8.00	5	10.00	3.00	50
3	7.14	7	16.67	24	57.14	7	16.67	1	2.38	2.90	42
1	2.00	1	2.00	10	20.00	29	58.00	9	18.00	3.88	50
0	0.0	8	19.05	23	54.76	8	19.05	3	7.14	3.14	42
6	12.00	11	22.00	27	54.00	5	10.00	1	2.00	2.68	50
11	26.19	15	35.71	12	28.57	4	9.52	0	0.0	2.21	42
0	0.0	0	0.0	12	24.00	28	56.00	10	20.00	3.96	50
0	0.0	0	0.0	11	26.19	25	59.52	6	14.29	3.88	42
1	2.00	7	14.00	23	46.00	15	30.00	4	8.00	3.28	50
1	2.38	20	47.62	17	40.48	2	4.76	2	4.76	2.62	42
0	0.0	5	10.00	13	26.00	25	50.00	7	14.00	3.68	50
0	0.0	2	4.76	3	7.14	24	57.14	13	30.95	4.14	42
0	0.0	3	6.00	13	26.00	18	36.00	16	32.00	3.94	50
1	2.38	4	9.52	13	30.95	13	30.95	11	26.19	3.69	42
0	0.0	4	8.00	15	30.00	20	40.00	11	22.00	3.76	50
1	2.38	10	23.81	19	45.24	8	19.05	4	9.52	3.10	42
2	4.00	3	6.00	17	34.00	19	38.00	9	18.00	3.60	50
4	9.52	7	16.67	11	26.19	17	40.48	3	7.14	3.19	42
1	2.00	3	6.00	21	42.00	17	34.00	8	16.00	3.56	50
0	0.0	7	16.67	5	11.90	24	57.14	6	14.29	3.69	42
1	2.00	4	8.00	14	28.00	24	48.00	7	14.00	3.64	50
0	0.0	4	9.52	19	45.24	16	38.10	3	7.14	3.43	42
1	2.00	0	0.0	10	20.00	33	66.00	6	12.00	3.86	50
1	2.38	3	7.14	9	21.43	23	54.76	6	14.29	3.71	42

		Response Categories									
		1		2		3		4		5	
Item		N	%	N	%	N	%	N	%	N	
59	ISSQ	2	4.00	3	6.00	29	58.00	11	22.00	5	10.
	BDF	0	0.0	1	2.38	6	14.29	30	71.43	5	11.
60	ISSQ	0	0.0	0	0.0	9	18.00	20	40.00	21	42.
	BDF	0	0.0	2	4.76	10	23.81	14	33.33	16	38.
61	ISSQ	0	0.0	3	6.00	9	18.00	24	48.00	14	28.
	BDF	1	2.38	1	2.38	4	9.52	21	50.00	15	35.
62	ISSQ	0	0.0	2	4.00	15	30.00	26	52.00	7	14.
	BDF	0	0.0	1	2.38	14	33.33	18	42.86	9	21.
66	ISSQ	1	2.00	3	6.00	11	22.00	27	54.00	8	16.
	BDF	0	0.0	6	14.29	30	71.43	5	11.90	1	2.
67	ISSQ	0	0.0	2	4.00	15	30.00	26	52.00	7	14.
	BDF	2	4.76	7	16.67	23	54.76	8	19.05	2	4.
68	ISSQ	1	2.00	12	24.00	27	54.00	6	12.00	4	8.
	BDF	1	2.38	8	19.05	20	47.62	12	28.57	1	2.
70	ISSQ	0	0.0	5	10.00	12	24.00	23	46.00	10	20.
	BDF	1	2.38	2	4.76	10	23.81	20	47.62	9	21.
76	ISSQ	0	0.0	1	2.00	9	18.00	31	62.00	9	18.
	BDF	0	0.0	1	2.38	10	23.81	16	38.10	15	35.
80	ISSQ	0	0.0	0	0.0	14	28.00	11	22.00	25	50.
	BDF	0	0.0	1	2.38	6	14.29	20	47.62	15	35.
TOTAL	ISSQ	27	1.35	131	7.55	686	34.30	809	40.45	327	16.
	BDF	39	2.32	181	10.77	587	34.94	638	37.98	235	13.

NEW ITEMS

		RESPONSE CATEGORIES									
		1		2		3		4		5	
ITEM		N	%	N	%	N	%	N	%	N	
2	ISSQ	0	0.00	0	0.00	11	22.00	32	64.00	7	14.
7	ISSQ	2	4.00	5	10.00	18	36.00	20	40.00	5	10.
9	ISSQ	3	6.00	5	10.00	35	70.00	6	12.00	1	2.
10	ISSQ	0	0.00	9	18.00	28	56.00	9	18.00	4	8.
11	ISSQ	0	0.00	8	16.00	23	46.00	11	22.00	8	16.
12	ISSQ	1	2.00	9	18.00	26	52.00	9	18.00	5	10.
18	ISSQ	0	0.00	2	4.00	12	24.00	26	52.00	10	20.
19	ISSQ	1	2.00	2	4.00	12	24.00	30	60.00	5	10.
21	ISSQ	0	0.00	0	0.00	14	28.00	24	48.00	12	24.
23	ISSQ	0	0.00	2	4.00	19	38.00	24	48.00	5	10.
24	ISSQ	0	0.00	2	4.00	14	28.00	25	50.00	9	18.

Response Categories 1 N	%	2 N	%	3 N	%	4 N	%	5 N	%	Mean Response	N
2	4.00	3	6.00	29	58.00	11	22.00	5	10.00	3.28	50
0	0.0	1	2.38	6	14.29	30	71.43	5	11.90	3.93	42
0	0.0	0	0.0	9	18.00	20	40.00	21	42.00	4.24	50
0	0.0	2	4.76	10	23.81	14	33.33	16	38.10	4.05	42
0	0.0	3	6.00	9	18.00	24	48.00	14	28.00	3.98	50
1	2.38	1	2.38	4	9.52	21	50.00	15	35.71	4.14	42
0	0.0	2	4.00	15	30.00	26	52.00	7	14.00	3.76	50
0	0.0	1	2.38	14	33.33	18	42.86	9	21.43	3.83	42
1	2.00	3	6.00	11	22.00	27	54.00	8	16.00	3.76	50
0	0.0	6	14.29	30	71.43	5	11.90	1	2.38	3.02	42
0	0.0	2	4.00	15	30.00	26	52.00	7	14.00	3.76	50
2	4.76	7	16.67	23	54.76	8	19.05	2	4.76	3.02	42
1	2.00	12	24.00	27	54.00	6	12.00	4	8.00	3.00	50
1	2.38	8	19.05	20	47.62	12	28.57	1	2.38	3.10	42
0	0.0	5	10.00	12	24.00	23	46.00	10	20.00	3.70	50
1	2.38	2	4.76	10	23.81	20	47.62	9	21.43	3.81	42
0	0.0	1	2.00	9	18.00	31	62.00	9	18.00	3.96	50
0	0.0	1	2.38	10	23.81	16	38.10	15	35.71	4.07	42
0	0.0	0	0.0	14	28.00	11	22.00	25	50.00	4.22	50
0	0.0	1	2.38	6	14.29	20	47.62	15	35.71	4.17	42
27	1.35	131	7.55	686	34.30	809	40.45	327	16.35	3.63	
39	2.32	181	10.77	587	34.94	638	37.98	235	13.99	3.51	

NEW ITEMS

RESPONSE CATEGORIES 1 N	%	2 N	%	3 N	%	4 N	%	5 N	%	MEAN RESPONSE	N
0	0.00	0	0.00	11	22.00	32	64.00	7	14.00	3.92	50
2	4.00	5	10.00	18	36.00	20	40.00	5	10.00	3.42	50
3	6.00	5	10.00	35	70.00	6	12.00	1	2.00	2.94	50
0	0.00	9	18.00	28	56.00	9	18.00	4	8.00	3.16	50
0	0.00	8	16.00	23	46.00	11	22.00	8	16.00	3.38	50
1	2.00	9	18.00	26	52.00	9	18.00	5	10.00	3.16	50
0	0.00	2	4.00	12	24.00	26	52.00	10	20.00	3.88	50
1	2.00	2	4.00	12	24.00	30	60.00	5	10.00	3.72	50
0	0.00	0	0.00	14	28.00	24	48.00	12	24.00	3.96	50
0	0.00	2	4.00	19	38.00	24	48.00	5	10.00	3.64	50
0	0.00	2	4.00	14	28.00	25	50.00	9	18.00	3.82	50

Response Categories

Item		1		2		3		4		5	
		N	%	N	%	N	%	N	%	N	%
25	ISSQ	2	4.00	5	10.00	25	50.00	15	30.00	3	6.
26	ISSQ	1	2.00	5	10.00	11	22.00	28	56.00	5	10.
27	ISSQ	2	4.00	6	12.00	24	48.00	13	26.00	5	10.
28	ISSQ	1	2.00	2	4.00	13	26.00	24	48.00	10	20.
30	ISSQ	1	2.00	7	14.00	21	42.00	19	38.00	2	4.
34	ISSQ	0	0.00	4	8.00	13	26.00	28	56.00	5	10.
37	ISSQ	0	0.00	4	8.00	9	18.00	34	68.00	3	6.
38	ISSQ	0	0.00	6	12.00	9	18.00	28	56.00	7	14.
39	ISSQ	0	0.00	6	12.00	24	48.00	16	32.00	4	8.
40	ISSQ	0	0.00	5	10.00	31	62.00	8	16.00	6	12.
41	ISSQ	0	0.00	5	10.00	14	28.00	25	50.00	6	12.
51	ISSQ	0	0.00	2	4.00	37	74.00	11	22.00	0	0.
52	ISSQ	2	4.00	8	16.00	21	42.00	15	30.00	4	8.
54	ISSQ	1	2.00	2	4.00	26	52.00	17	34.00	4	8.
55	ISSQ	0	0.00	5	10.00	30	60.00	10	20.00	5	10.
56	ISSQ	0	0.00	0	0.00	7	14.00	40	80.00	3	6.
57	ISSQ	0	0.00	0	0.00	12	24.00	34	68.00	4	8.
63	ISSQ	0	0.00	1	2.00	13	26.00	31	62.00	5	10.
64	ISSQ	3	6.00	3	6.00	21	42.00	15	30.00	8	16.
65	ISSQ	1	2.00	3	6.00	22	44.00	20	40.00	4	8.
69	ISSQ	0	0.00	2	4.00	39	78.00	7	14.00	2	4.
71	ISSQ	0	0.00	0	0.00	8	16.00	30	60.00	12	24.
72	ISSQ	0	0.00	2	4.00	37	74.00	8	16.00	3	6.
73	ISSQ	1	2.00	1	2.00	9	18.00	28	56.00	11	22.
74	ISSQ	0	0.00	4	8.00	15	30.00	25	50.00	6	12.
75	ISSQ	2	4.00	5	10.00	19	38.00	18	36.00	6	12.
77	ISSQ	0	0.00	0	0.00	16	32.00	32	64.00	2	4.
78	ISSQ	0	0.00	5	10.00	12	24.00	26	52.00	7	14.
79	ISSQ	2	4.00	8	16.00	14	28.00	17	34.00	9	18.
TOTAL	NEW	26	1.30	150	7.50	764	38.20	838	41.90	222	11.
	ALL	53	1.32	301	7.52	1450	36.25	1647	41.17	549	13.

Response Categories 1 N	1 %	2 N	2 %	3 N	3 %	4 N	4 %	5 N	5 %	Mean Res-ponse	N
2	4.00	5	10.00	25	50.00	15	30.00	3	6.00	3.24	50
1	2.00	5	10.00	11	22.00	28	56.00	5	10.00	3.62	50
2	4.00	6	12.00	24	48.00	13	26.00	5	10.00	3.26	50
1	2.00	2	4.00	13	26.00	24	48.00	10	20.00	3.80	50
1	2.00	7	14.00	21	42.00	19	38.00	2	4.00	3.28	50
0	0.00	4	8.00	13	26.00	28	56.00	5	10.00	3.68	50
0	0.00	4	8.00	9	18.00	34	68.00	3	6.00	3.72	50
0	0.00	6	12.00	9	18.00	28	56.00	7	14.00	3.72	50
0	0.00	6	12.00	24	48.00	16	32.00	4	8.00	3.36	50
0	0.00	5	10.00	31	62.00	8	16.00	6	12.00	3.30	50
0	0.00	5	10.00	14	28.00	25	50.00	6	12.00	3.64	50
0	0.00	2	4.00	37	74.00	11	22.00	0	0.00	3.18	50
2	4.00	8	16.00	21	42.00	15	30.00	4	8.00	3.22	50
1	2.00	2	4.00	26	52.00	17	34.00	4	8.00	3.42	50
0	0.00	5	10.00	30	60.00	10	20.00	5	10.00	3.30	50
0	0.00	0	0.00	7	14.00	40	80.00	3	6.00	3.92	50
0	0.00	0	0.00	12	24.00	34	68.00	4	8.00	3.84	50
0	0.00	1	2.00	13	26.00	31	62.00	5	10.00	3.80	50
3	6.00	3	6.00	21	42.00	15	30.00	8	16.00	3.44	50
1	2.00	3	6.00	22	44.00	20	40.00	4	8.00	3.46	50
0	0.00	2	4.00	39	78.00	7	14.00	2	4.00	3.18	50
0	0.00	0	0.00	8	16.00	30	60.00	12	24.00	4.08	50
0	0.00	2	4.00	37	74.00	8	16.00	3	6.00	3.24	50
1	2.00	1	2.00	9	18.00	28	56.00	11	22.00	3.94	50
0	0.00	4	8.00	15	30.00	25	50.00	6	12.00	3.66	50
2	4.00	5	10.00	19	38.00	18	36.00	6	12.00	3.42	50
0	0.00	0	0.00	16	32.00	32	64.00	2	4.00	3.72	50
0	0.00	5	10.00	12	24.00	26	52.00	7	14.00	3.70	50
2	4.00	8	16.00	14	28.00	17	34.00	9	18.00	3.46	50
6	1.30	150	7.50	764	38.20	838	41.90	222	11.10	3.54	
3	1.32	301	7.52	1450	36.25	1647	41.17	549	13.72	3.58	

The second section of Table 2 (NEW ITEMS) lists the responses of the staff at LCCH to new items on the ISSQ which were not included in the BDF. At the end of this section, are the total scores for the institution's staff on the 40 new items, exclusive to the ISSQ. In addition, total scores for the staff on all 80 ISSQ items are given.

First, to discuss how the table is to be read: Let us take item #1 among the 40 old items, "Quality of intake procedures..." Out of a total number (N=50) of respondents from LCCH on the 1973 ISSQ, 2% rated LCCH on this item as 2 (Fair); 32% gave a rating of 3 (Satisfactory); 48% gave a rating of 4 (Good); 18% gave a rating of 5 (Excellent). And so for each item. The 1972 responses to the BDF for those questions are listed immediately below the ISSQ responses and are to be read in exactly the same way.

On an overall basis, 16.35% of the respondents from LCCH gave their institution a mean rating of 5 (Excellent) on these 40 ISSQ items, compared with 13.98% for the BDF in 1972--a gain of 2.37%. With regard to specific items, most things looked better but some showed a decline in 1973 compared with 1972 at LCCH. For example, on item 42 [Adequacy of feedback to staff, parents, and (where feasible) each child concerning evidence of progress toward treatment goals] the mean response in 1973 on the ISSQ was 3.88; in 1972 the mean response was 3.14--a gain of .74 on a scale of five. On the other hand, for item 59 (Dependability of funding) the 1973 mean response was 3.28, whereas it was 3.93 in 1972--a loss of .65. Similar analyses can be made for each of the other items, and for each response rating within an item. At Lakecrest, only 14 items (4, 5, 14, 15, 16, 17, 46, 50, 59, 61, 62, 68, 70, 76) out of the 40 comparable items received a higher score in 1972 compared with 1973. The mean score of the LCCH respondents for the entire 80 items on the ISSQ was 3.61 (p. 4, Table 2). Direct comparison with the mean total score on the BDF is problematic because 40 items on the BDF were changed--although all items on both the BDF and the ISSQ represent features of a children's residential center that have consensual support as being important and desirable. For the 40 items on which direct comparison can be made, the mean on the 1972 BDF was 3.51 compared with the mean on the ISSQ of 3.63--an insignificant difference.

A more detailed analysis of responses on the ISSQ has been sent in a separate letter to each institution that turned in their data for this study.

Perhaps the most valuable use that an institution can make of detailed analysis of responses that HIRI offers to furnish might be through staff participation in problem and opportunity identification coupled with problem-solving efforts. Aside from scores on individual items, analyses can be made of response differences in relation to age groups, male-female, treatment staff compared with support staff within the given institution, and comparisons between each institution and the overall mean scores for all other institutions that responded to the ISSQ.

E. A Commentary by Edward M. Glaser, PhD, Project Director, on the LCCH Consulting Intervention

The HIRI consultant, Mr. Robert Blinkenberg, noted at the beginning of his report that:

> In general, the agency, at the outset of consultation, seemed to be running smoothly with a well qualified and productive staff. The organization as a whole seemed healthy and free of overt symptoms indicating any significant dysfunction. There was low turnover, compensation was above average for the profession, absenteeism was low, there was little counterproductive behavior, employees seemed to identify with the organization, social integration was moderately high, and the agency seemed adaptable.

Thus, the consultant entered into a system that respected itself for valid reasons, thus was free enough of self-concern to give of itself--to its clients and to its own continued development.

The consultant stated his orientation as follows:

> Consultation was based on the belief that an organization is a learning, developing system. This approach assumes that organizations are capable of utilizing outside resources to effect immediate internal operating improvements as well as to effect long-term improvements in their capability to cope with and adapt to a changing environment.

Then, naturally building upon his own type of training-experience background, his planned intervention followed an outline of (1) operation and analysis (diagnosis), (2) assessment, (3) planning, (4) action, (5) evaluation. A special emphasis of this particular consultant was on negotiating working "contracts" with the institution, whereby goals were initially set, priorities determined and decisions made about resource allocation. The action phase began once the "contracts" were negotiated.

This emphasis on establishing "contracts" might work well for this particular consultant because it is his natural style. For some other consultants it might get in the way of establishing a trustful, easy relationship; it might prove over-rigid and over-"legalistic."

The diagnostic phase (described on pp. 18-19) proved very valuable. It surfaced a number of important problems for the staff and consultant to examine together. The assessment phase, using HIRI's Baseline Data Form, added depth to problem-opportunity identification. The planning resulted in a series of "contracts" that represented agreement between staff and consultant regarding the problems/opportunities they would work on. The action phase was divided into (a) workshops, exercises, "contracts" with individuals, and problem-solving meetings; (b) the process of the relationship between the consultant and the institution staff.

While the consultant was perceived by several persons on the LCCH staff as being impatient, coming on almost like "gangbusters" at times, he nevertheless was trusted and respected as a completely sincere, friendly, knowledgeable and very bright person who warmly identified with the desire of the client organization to improve itself. That kind of personal relationship provides a context in which given idiosyncracies of behavioral style can be accepted in a spirit of affirming good will rather than negating resistance.

The responses from interviewees reported by the independent evaluator, plus his summary of the composite response of those interviewed, make a further commentary on my part largely unnecessary. I would add only that LCCH was very able to profit from the stimulation of the consultation because (1) it had full support and active participation by a nondefensive director, (2) the staff was ready and willing to consider ideas for improvement because they already were engaged in constructive developmental ferment before HIRI began to consult with them. Thus, the environmental soil was favorable to receive, without a feeling of threat or resistance, the consultant's opening suggestion of a diagnostic phase, which assumed that even a healthy organization--or any human organization on this side of Paradise--can be better, despite a relatively superior batting average. This diagnosis uncovered many problems and opportunities which the staff felt important, and which they then wanted to work on. If the soil had not been favorable, then, like a good gardener (to carry the analogy with the soil), a first task would be to work on development of needed soil conditions before attempting to undertake certain kinds of planting.

Another kind of commentary which seems appropriate to include here is one offered by a social worker on the LCCH staff almost a year after termination of the consulting intervention. This follows as Appendix 1.

APPENDIX 1

Comments on the HIRI Consultation Impact Made at the California Association of Children's Residential Centers Meeting

At a California Association of Children's Residential Centers (CACRC) meeting in San Diego on May 29, 1974, LCCH and Red Rock staff gave a report and evaluation of the HIRI consultation impact to the CACRC membership (representatives from 58 institutions). The following comments made by one of the social workers on the LCCH staff were transcribed (with minor editing for clarity) from a recording of the meeting.

> There have been a number of payoffs to the agency from HIRI's stimulation of us toward goal planning for each child, a team approach, and objectives-setting.
>
> In terms of the client, the crucial thing is the client is getting better service. I think that just in the families I'm serving I see that a change in the team's approach rubs off onto the kids and their families. They are being served by a more energetic and responsive, enthusiastic group of people who generally feel that what they are doing counts. It's not like we are spinning our wheels and not getting anywhere--we do see results. We've had to define what we want in different ways; in terms of what we want, we are getting more of it. The treatment focus is more specific, and it takes into account the realistic limitations of the family systems.
>
> I'll give you an example. Two years ago a child came in and the first report that was written after the staffing was titled Treatment Planning Recommendations which had at the conclusion a rather lengthy summary of where the child was seen in terms of treatment: (1) continue to offer him treatment, (2) continue present medication, and (3) continue trying to establish meaningful relationships.
>
> What we have now is more specific. We have a number of goals, and I'm just citing one--the one that dovetails with continued trying to establish relationships. We've broken it down into a concern, a goal, a method, and an indicator. You can use your indicator as a predictive tool to help the family, and feel that you are more in control of what's happening or what might happen. The worst thing that can happen is that you're wrong, and if you're wrong it doesn't matter that much because you move on to another goal, and figure out why you were wrong.
>
> A final payoff to the client is that our statistics show that time required for care has decreased. In 1965, length of care was 30 months at the Children's Home. In 1969, it was down to 20 months; in 1970, it was

down to 15 months. In the last fiscal year, it was down to 10.7 months. I don't know exactly how the treatment is related to management by objectives--but it's in there, and my hunch is that MBO has a lot to do with our decrease in needed length of care because it provides a clearer idea about when you've reached maximum effectiveness. The point at which treatment is no longer really beneficial is clearer now to all concerned. Instead of staff feeling an investment in the child and, therefore, being hesitant to release him because he's really not quite ready, you have more objective criteria for discharge. A third payoff is service to the community. If it's really true that the length of stay is decreasing, then naturally you are able to serve more children in the community; and even though the cost of the other care is going up, your total treatment cost is actually going down in these cases. Also, in terms of linkage to other agencies, you can be more helpful to other agencies in terms of referrals in that you have a better idea of when you're specific about what you really are providing, and vice-versa. When you send a kid out, you can be more specific in helping the recipient agency understand what Johnny's problems are.

I'd like to take a second to stress some of the commonly expressed concerns about moving into this type operation of goal-orientation. One is that you are less free-wheeling, spontaneous, autonomous--you can't do your own thing. Yes, that's true in a way, but also you are more effective in the end to focus on what you really want to do. A second frequently expressed concern is that you may be forced to establish goals which are either empty or have no therapeutic value. Or you are becoming another welfare department. Or you just have to come up with some garbage. An answer to that is that there are good goals and there are bad goals. You have a choice of what you want to set out to accomplish. A third frequently expressed concern is you are forced to feel that behavior, rather than attitudes is the most important thing to focus on. That is, you are forced into a behavior-modification system, whether you want to operate that way or not. Some of you, I know, do that out of choice and others have other theories or treatment modalities. You are not forced into any treatment modality other than what you want. All you have to do is be more specific about what you are trying to accomplish. The behavioral changes offer the first sign that something underlying is changing, that's true. Another concern is "1984" (bringing on of)--any time you become more mechanized, you run the risk of putting people in slots. Actually to my surprise and great relief, I find the opposite. We are forced to individualize, and the goals we set and the approaches we are trying to take depend solely on the actual material, the actual things that are happening with each child. A fifth concern is that accountability means less autonomy. To that, I might answer yes and no. There's more interdependence and specialization when you're working better together as a team, but this can also mean a lot more freedom, a lot more relief that what is said is what we want to get done and is actually what gets done. To be sure, making any change such as a move in the direction of goal planning involves taking a risk. A sixth contention is that when you are forced to commit your ideas to paper you lose the "feel" of what's going on. I think, to an extent, that's true because when you are specific you have to be selective which means you have to exclude certain material, but I think the total picture is still there. You can express all that you are doing--selecting out consciously those matters which you are attempting to change at a particular time. Another concern is that of "sticking your neck out"--in other words, how can you know what might happen to Johnny 3 to 6 months from now. The answer, obviously, is that you don't. But by setting a goal you are not stating that you guarantee that Johnny will be less withdrawn; you are simply hoping that this will happen and devising specific methods which you hope will work. It may or may not. However, what you're doing is setting up working hypotheses, and it's not a simple matter of dealing with black or white.

APPENDIX 2

ACTIVITY REPORT #9 - LAKECREST CHILDREN'S HOME

Bob Blinkenberg October 9, 1972

Names and Job Titles

A, Executive Director
B, Associate Executive Director*
C, Unit Coordinator
D, Intake Coordinator
E, Social Worker and Unit Supervisor
F, Community Development Worker
G, Unit Supervisor
H, Unit Coordinator
X, Unit Supervisor

Plus an assortment of these individuals and many other (total of 20) in a later meeting.

* a recent (Oct. 9) promotion.

Activity Description

On Monday morning Jean and I attended the administrative conference. This conference had on its agenda: (1) feedback on the CACRC meeting in SF; (2) review of research project; (3) agency security; and (4) staff development program.

On Monday afternoon we held our feedback and discussion meeting. The announced intentions of this meeting were to verify or deny our feedback and begin to constructively respond to any concomitant dissatisfaction.

Information Gathered

In the administrative staff conference the first topic taken up was the staff development program. This program is the brain child of X and is intended to focus on improving the capability and effectiveness of the institution's staff.

X described and reviewed the progress of the program to date--a surprise for us! He: (1) had obtained a list of their greatest agency-oriented concerns from each administrative staff member; (2) had listed all of these in a single compilation; and (3) then requested each administrative staff member (again) to rank the 15 most important concerns from the overall list. In the meeting X reported the results. The highest ranked (greatly outranking the rest of the items) were the clustered items of: (1) treatment of children; (2) communication; and (3) cultural "diversity."

After this report the discussion properly turned toward deciding what to do from here. At this point Jean and I, consistent with our announced advance into the action phase, began to play our active, questioning role.

X's suggestion was that the exercise be repeated for the entire staff as had been done with administrative staff. Much discussion ensued with myself, Jean and X questioning the underlying or implied posture. X was not particularly defensive and the discussion was most constructive.

The discussion continued with the question of what X or whoever would do if: (1) the results were the same; or (2) if they were different. It was agreed that a verification was what was really being sought; no one was expecting markedly new inputs. I remarked that this attitude encouraged continuation of a feeling of separation between the administration and the rest of the staff. This was tossed around and tentatively admitted.

The staff was about to drop the question, having gotten agreement to pursue it roughly as X had planned when I intervened. I pointed out how X's program and ours had at least overlapping objectives and we should talk about the match and/or possible conflict. I further pointed out that even if two programs had similar objectives but were on different schedules, conflict could result.

I then described our schedule and emphasized that our intentions were to deal with some problems hopefully to the point of initiating resolving efforts that very afternoon.

I also pointed out that the data we had collected through our interviews could easily serve as verifying data (from the entire staff) for the data which X had collected separately from the administrative staff. A lengthy discussion ensued.

Finally the whole subject was opened up of what were we doing or going to be doing there anyway. The staff happily took this as an opportunity to test the relationship. There were questions of what is a "contract"; were these going to be private or manipulative; who were we working for; weren't we preempting some management prerogatives; did we really expect to get so actively involved. It all seemed a very timely discussion because everyone chimed in, including A, and had questions.

We tried to explain that contract meant simply a mutual agreement; we would only undertake to help individuals or groups cope better with their environment, not manipulatively change it; we had no authority as such; we would only help where asked; we were working for the whole organization; and, yes, we really expected to be actively involved (as made evident by that very meeting).

This discussion cleared up a lot of vagueness if not real misunderstanding. We were left with a lack of complete certainty on how attractive this left us but at least any further progress was now going to be based on accurate perceptions.

The discussion concluded by X requesting that we go ahead with the meeting but not progress too far with "contract making" with the staff--this request gained general concurrence and we accepted it completely.

The final topic was agency security and was used to gently disengage from the preceding discussion as well as focus on the immediate topic. This was well handled by A and seemed most useful (rather than just dramatically breaking up at the close of our previous discussion).

The afternoon meeting began with A requesting me to open it with a statement of purpose. I replied that we were assembled to discuss, amplify, verify, deny and/or generally focus on the written feedback. I checked with the staff and all but three had had previous chance to go over it. Jean added a few comments. A added a few comments. All was quiet.

Then happily, the dam burst. We started by answering a few questions of clarification on the personnel practices topic and there launched a full scale assault on topic 1--cost/quality of care.

There ensued a good exchange of information, feelings, etc. The staff dealt with this topic without our assistance. We semi-deliberately let them warm up. At one point I whispered a caution to A that for our purposes he was leading the meeting too much. He concurred and refrained.

The subject of cost awareness came up and the idea of unit-defined cost centers was proposed. B submitted that this proposal was already under review and promised to hustle it along and keep the staff advised. I think he also realized that they wanted and needed to be a part of the review and have a part in the decision making. Real progress. The discussion proceeded from abstract conceptualizing to concrete, constructive suggestions.

They then, in order, dealt with the staff changes topic. This was super current. A had not yet officially announced B's promotion to R's job. He, in fact, had said it must wait for review by the minority staff (unofficial) committee. The staff and I kept challenging him, as did a minority staff member who has been active on the "committee," as to why it had to wait. They were only to be a rubber stamp and didn't like it. A finally agreed and in fact announced right there that the promotion was immediately effective. There was a delightful reaction!

There was also clarification of just what A's meeting with the "minority committee" was for--to approve some policy suggestions relating to LCCHA's affirmative action program, specifically what positions were grouped together for purposes of computing the parity situation.

After continued discussion which I cannot adequately capture, the tempo slowed and I sensed closure. I tested this and asked for their reactions. We got a few questions (again) on where we stood (Are you in administration? No. Are you only going to work within the administration building/staff? No.). The reaction finally shared was quite positive and they wanted to continue (having covered less than half the topics) and we arranged to meet same time on Monday the 16th (hence the two day visit next week to include the annual Board meeting on the 17th).

I also got a fun comment from one of the best looking girls on the premises, a blonde social worker--"I think you have a very attractive service, and I'd like to see you in the unit..." All I could do was giggle. I did however, after adjournment, close the loop and thank her for being the first to suggest any continuing "contract" and pointed out that those kinds of requests were just what we were waiting for and needed so vitally.

R. L. Blen

Client Consultant

Organization Design Worksheet

Function: Responsibility for agency-wide staff development and Unit staff training (including Clerical staff)

	Board of Trustees	Executive Director	Assoc. Exec. Director	Unit Supervisor	Unit Coordinator	Social Worker	Child Dev. Counsel	Childre	
Who has operating responsibility? (Makes operating decisions)				✓					
Who is typically involved in the process?					✓				
Who evaluates results and effectiveness?			✓						

What information is appropriate for evaluating results and effectiveness? How does evaluator get information?

1. How was money spent
2. Was the program effective

What is the evaluation and feedback cycle? How often? What form?

Comments Unit supervisors want responsibility for the design of this item.

Unit Coordinators want to participate in it design implemen

Client

R. L. Blankenberg #2
Consultant

Date 3-30-73

Organization Design Worksheet

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1. How was money spent
2. Was the program effective

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supervisors want responsibility for the design function
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Coordinators want to participate in design + implementation function

APPENDIX 3

R. L. Blen
Client
Consultant

Organization Design Worksheet

Function: Responsibility for agency-wide staff development and Unit staff training (including clerical staff).

	Board of Trustees	Executive Director	Assoc. Exec. Director	Unit Supervisor	Unit Coordinator	Social Worker	Child Dev. Counsel	Childre	
Who has operating responsibility? (Makes operating decisions)				✓					
Who is typically involved in the process?					✓				
Who evaluates results and effectiveness?			✓						

What information is appropriate for evaluating results and effectiveness? How does evaluator get information?

1. How was money spent
2. Was the program effective

What is the evaluation and feedback cycle? How often? What form?

Comments Unit supervisors want responsibility for the design of this item.
Unit Coordinators want to participate in design + implemen

Client

R.L. Blenkenberg #2
Consultant
Date 5-30-73

Organization Design Worksheet

ponsibility wide pment and : raining cal staff.	Board of Trustees	Executive Director	Assoc. Exec. Director	Unit Supervisor	Unit Coordinator	Social Worker	Child Dev. Counselor	Children	Support Staff	Clerical Staff		
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Coordinators want to participate in ^design^ implementation function "/

APPENDIX 3

RED ROCK

A. Summary Description of the Institution

Red Rock was founded 60 years ago as an orphanage and has evolved quickly over the past 10 years into a residential treatment center for children. The home is a nonprofit, nonsectarian organization operated by a church denomination. It is governed by a board of directors consisting of 24 members. The annual budget for the agency is approximately $500,000.

Red Rock has specialized in younger children, boys and girls aged 8 to 13, without overt physical or mental disabilities. Many of the children come from unfortunate home environments, and have developed emotional and behavioral characteristics which have led to their rejection by the natural family, foster families, and public schools. Average residency is 40 children in four cottages on the agency's main campus, six boys in a prototype satellite home in a nearby community, and six girls in a recently opened, similar satellite home. Children are accepted through county and private placement.

The task of Red Rock is to provide the personal, social, and educational development necessary for the child to return to a family environment. The staff also works to prepare the environment into which the child will go, by providing therapeutic services to parents, developing foster parents, or seeking adoptive families for the children. Although most of the children attend local city schools, special educational programs on campus provide intensive help for those who cannot yet succeed in the public school program.

B. What the Consultant Thought He Was Trying to Do at Red Rock

The following statement of objectives, perceptions and strategies of consultation was prepared by the HIRI consultant to this particular institution, Thomas Hallam, M.B.A., and candidate for PhD in the Graduate School of Management, UCLA.

1. Overview

In August, 1972 the physical environment of Red Rock struck me as being old and poor-looking. Situated on ten hilly acres in an old residential area, the main buildings did not hide their 60 years of service as children's residences. The grounds and buildings were neat and clean, but the effects of many years of minimum budget for maintenance and improvements were evident. In all, however, the campus had a warmth and comfort about it. I found the staff to be a youthful, noisy, very casually clad group pursuing their activities with refreshing energy.

Red Rock was doing a satisfactory job in the residential treatment of children. It was very well thought of by others in the field, and was facing no present or foreseeable crises. The organization had its share of problems, and was coping with them. The most important characteristic I found was a strong feeling on the part of staff at all levels, from child care workers to the executive director, that they were capable of doing a much better job and were clearly dissatisfied with their current level of functioning.

The expressions of dissatisfaction were different in the different working groups, but it later became evident that the dissatisfactions were basically the same. The executive director felt that the center had progressed through 10-year cycles of major change, stabilization, growing dissatisfaction, and then another major change, and that the dissatisfaction was beginning to peak. Social workers felt that the center was overemphasizing the physical and custodial care of children as evidenced by the isolated, weak organizational position of the social workers. Child care workers believed that too much of the center's limited resources were being expended on administrative matters, to the detriment of the cottage program.

This was certainly an opportune time to begin the organizational consultation. Because of this common belief that Red Rock could be better and a willingness to change, the staff was very receptive to the program of organizational renewal I presented over the year.

When I began the consultation, my relevant experience had consisted of approximately a year of providing organizational consultation to working groups in a major manufacturing company. I was working actively on a PhD in management, with cognates in behavioral science and child development.

The theoretical perspective with which I approached this consultation is called the systems approach, or open systems theory, or an organismic model. In overview, it requires that the organization discover its central identity or mission in relation to its environment and that it then structure itself and employ its resources to effectively perform that mission. The focus of change is on the organization as a whole, and not directly on individuals. The most important goal of such consultation is for the staff to acquire the perspective necessary to see themselves as a working system with considerable freedom to be and do the best that their collective capacities can create. This kind of learning fosters not only a current reorganization for improved effectiveness but, more importantly, a process of continual self-review and revision to meet constantly changing conditions.

2. The Year's Experience

The pace of the consultation, about 3 days each month, was fairly constant throughout the year. The first 2 months were spent getting oriented, meeting the staff, and observing many of the functions of the center. The next 3 months began with some shaky interventions and ended with a well-defined focus and objective for the remainder of the consultation. The final 6 months were dedicated to developing and implementing a model treatment program as the central mission of Red Rock.

3. Orientation and Observation

Through a series of individual and group interviews, and by observing a number of the meetings that make up the Red Rock routine, I met and talked with almost all of the staff and began to get some feel for Red Rock as a functioning organization.

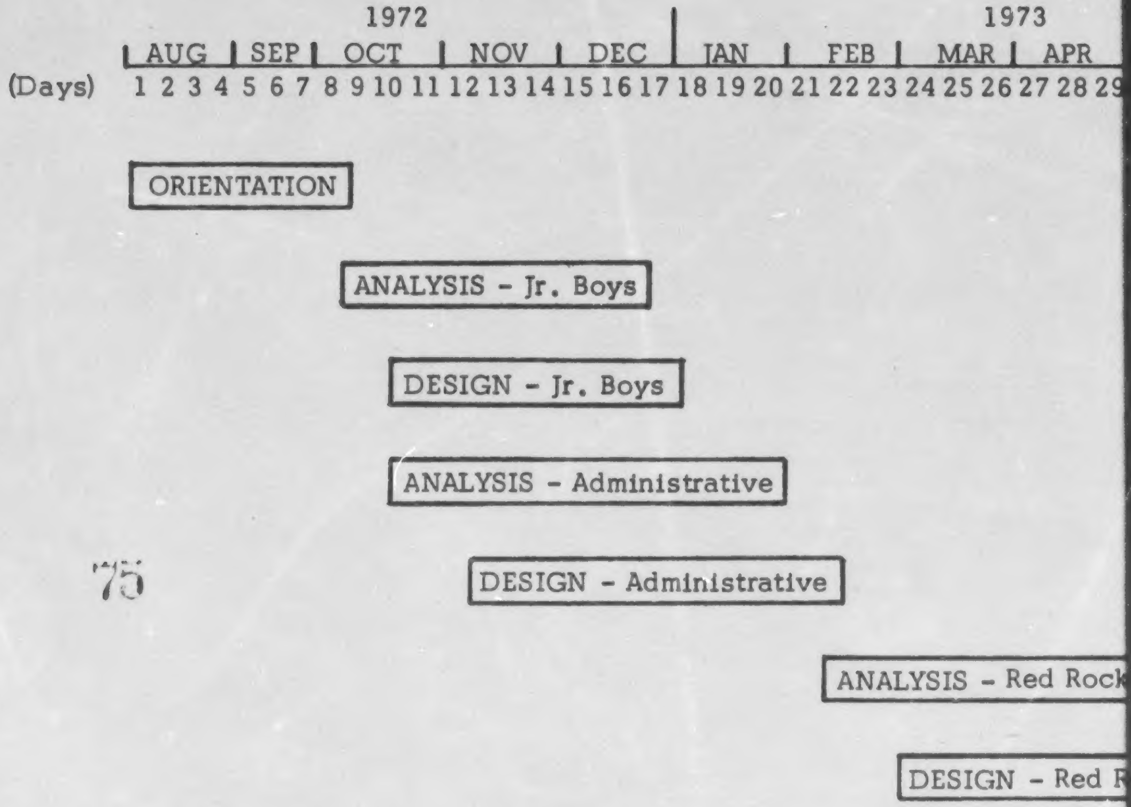
In introducing myself and the project to the staff, I told them I would be with the center for a year and that I was interested in finding ways to improve the effectiveness of Red Rock as a children's residential center (CRC). My reception among the various groups ranged from neutral to quite positive.

The schedule of the research project allowed me the luxury of a gradual, low-pressure introduction to the staff, and this became a valuable asset later in the consultation. During the early weeks of the consultation I truly had no personal agenda as I observed the organization in action, and I believe that this conveyed to the staff my respect for the job they were currently doing as well as my interest in learning from them before attempting to teach them.

The orientation and observation phase of the consultation came to a close with a plan (developed by me) for the remainder of the year. This plan, presented as Figure I, proposed a focus first on one of the treatment teams (Jr. Boys) for the purpose of developing it into a model to be used in the later redesign of the entire agency program. Concurrent with the Junior Boys program, I would be working to design and implement a more effective administrative organization. This thrust reflected a desire on the part of the executive director for me to apply my management background in a review of the center's management systems. After the Junior Boys and administrative programs, the plan called for an integrated analysis and redesign of the entire organization. Finally, there would be a period of future planning to provide for the perpetuation of the progress made during the consultation year.

ORGANIZATION ANALYSIS AND DESIGN

RED ROCK



ORGANIZATION ANALYSIS AND DESIGN

RED ROCK

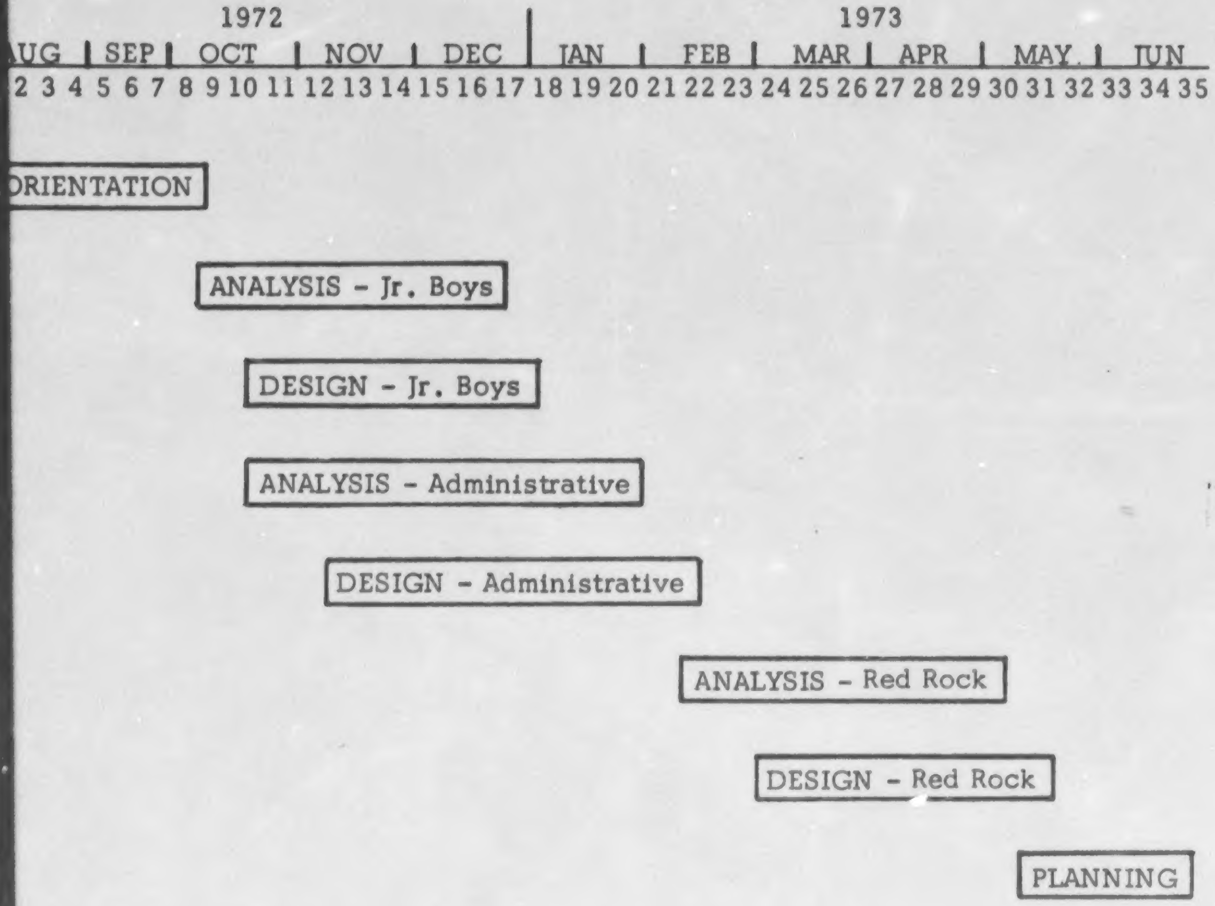


Figure I

4. The Initial Interventions

Although I did not foresee the need for such a phase, the primary accomplishment of this period in the consultation was to build a working relationship between me and the staff. As I attempted to move from an observing to a leading role in, for example, the Junior Boys program I found that the staff was not able or willing to provide the commitment I needed. Departing from my plan, I found myself pursuing opportunities for action wherever I could get the necessary commitment. This phase of initial interventions ended after 3 months, when I discovered that I had developed an identity in the organization that would support the kinds of intervention activities I had originally hoped to lead.

The first major intervention series in this period was the Junior Boys program. I asked them, as the pilot group for the planned consultation program, to accept my help in defining the tasks and processes that constitute the basis of the team's purpose at Red Rock, in analyzing the resources and constraints that affect the accomplishment of the tasks and processes, and in developing strategies for the use of resources and the responses to constraints to optimize their performance of the basic purpose. I knew that they did not fully understand what they were agreeing to, and I found when I began working with them the next week that I was not able to spark their enthusiasm for my grand plan. In retrospect I can see ways in which I could have led the group more effectively, but the important lesson for me was the need to provide for the needs of individuals and groups as well as the global organization improvement strategy. I met with them again in their weekly meeting to restore my role of interested observer, but never again pursued the idea of a pilot program.

As a part of the administrative thrust, I held a short seminar on motivation with much of the professional and administrative staff. I showed a film in which Frederick Herzberg presented his motivation theory, and then we discussed the relevance of his theory to the staff and children at Red Rock. The discussion was certainly productive. I think the event's greater importance was that it gave people some clues to the areas of my interest and competence.

Another activity during this period was one suggested to me by our project director. It involved meeting with a cross-section of administrative, professional, and child care staff and asking them individually to suggest ways in which they would improve Red Rock as a children's residential center without regard to cost or other constraints. The data were valuable in our later planning for the remainder of the consultation, and the process of conducting these structured discussions contributed to the growth of my identity in the center.

The period of initial interventions came to a close when I felt that we had enough experience in the consultation to attempt a deliberate plan for the remaining 6 months. This planning is the first event in the development and implementation of a model treatment program.

5. The Development and Implementation of a Model Treatment Program

The 6-month period comprising this phase was really the payoff of the consultation for me as well as for Red Rock. We put forth an effort that succeeded in restructuring the center's treatment program in a way that reflected the staff's own best thinking, and we gave the consultation a theme and a purpose that made my role clear.

This consultation phase really began when I asked the executive director and assistant director to plan our objectives for the remainder of the consultation with me. The outcome of this activity was a realization that our central interest was an improvement in the effectiveness of child treatment at Red Rock. We agreed to develop and implement a treatment program based on individualized goal plans to meet a current administrative need and an imminent legal requirement for a program evaluation mechanism. The executive director and the assistant director agreed to allow the staff the freedom to design the program as they wanted, within the constraints of a provision for evaluation and compliance with the formal policies of Red Rock.

As this work was underway with the administration, I pursued the idea of treatment goal planning with the social workers to see if it were a concept they could become committed to. They saw it as a formalization of something they had been using with several cases, and agreed to its adoption. Treatment goals were not the only way to accomplish the evaluation that we were seeking. Other CRCs have developed different techniques, such as the Devereaux Child Behavior Rating Scale, but the goal-planning method seemed to be more amenable to the treatment modalities and child needs at Red Rock. It was important that the staff, through the social workers, make this decision.

With the staff having agreed that goal planning would become the central theme in the treatment program, which would require significant changes from current practice, and the administration defining the bounds of freedom within which the staff could structure the program, the groundwork for designing a brand new organization was set. I assumed responsibility for developing a process for accomplishing the design, and in the resulting 1-day workshop we drafted the first cut at the new organization by defining new roles and responsibilities for the staff.

The work of developing this first draft of the model treatment program took the staff about a month. For the next 4 months the consultation focused on continuing the development of the model and implementing it at Red Rock. After the first draft was generated, however, the staff began doing much of the work without me. I was limited to spending about 1 day a week on the project, and I was delighted that to a large extent the energy to make progress was being generated in the center. In addition, I was suddenly in the position of having to budget my time among the demands rather than having to seek out opportunities to apply myself. (This observation is very well documented by the independent evaluator's findings, p. 80.)

In the draft model the core of the treatment process was the treatment team, composed of a social worker, a child care supervisor, and the child care staff. The child care staff's special skill was seen to be its ability to develop close relationships and mutual understanding with the children. Complementary responsibilities were designed for the supervisor and the social worker. The social worker was responsible for the formulation of clear and reasonable treatment plans and the supervisor was responsible for the child care staff's ability to facilitate the child's progress toward the goals in his personal treatment plan. The plans and progress would be reviewed regularly by the assistant director, and such review would form the basis for his evaluation of the team's performance. This is, of course, an overly simple summary of the program design.

One week after the workshop, one of the supervisors resigned (for reasons unrelated to the design process, to accept a position he had applied for months earlier). The staff viewed the vacancy created by his departure as an opportunity to improve the design of the supervisory levels of the treatment program, and created a new position of unit supervisor. This new supervisory position differed from the old one in that the new supervisor was also to perform the duties of child care staff and was a member of only one team. The team, then, was composed entirely of people actively working in the treatment of children.

Four weeks after the workshop, the staff devised a method for selecting candidates for the new supervisory positions using criteria based on the program model in an open process.

Seven weeks after the workshop, newly formed treatment plans were in effect for many of the children, and the teams were reporting a marked improvement in their ability to make observable progress with these children.

Ten weeks after the workshop, the treatment plans and progress reviews were begun, with the review participants developing the basic formats for the treatment records and the review.

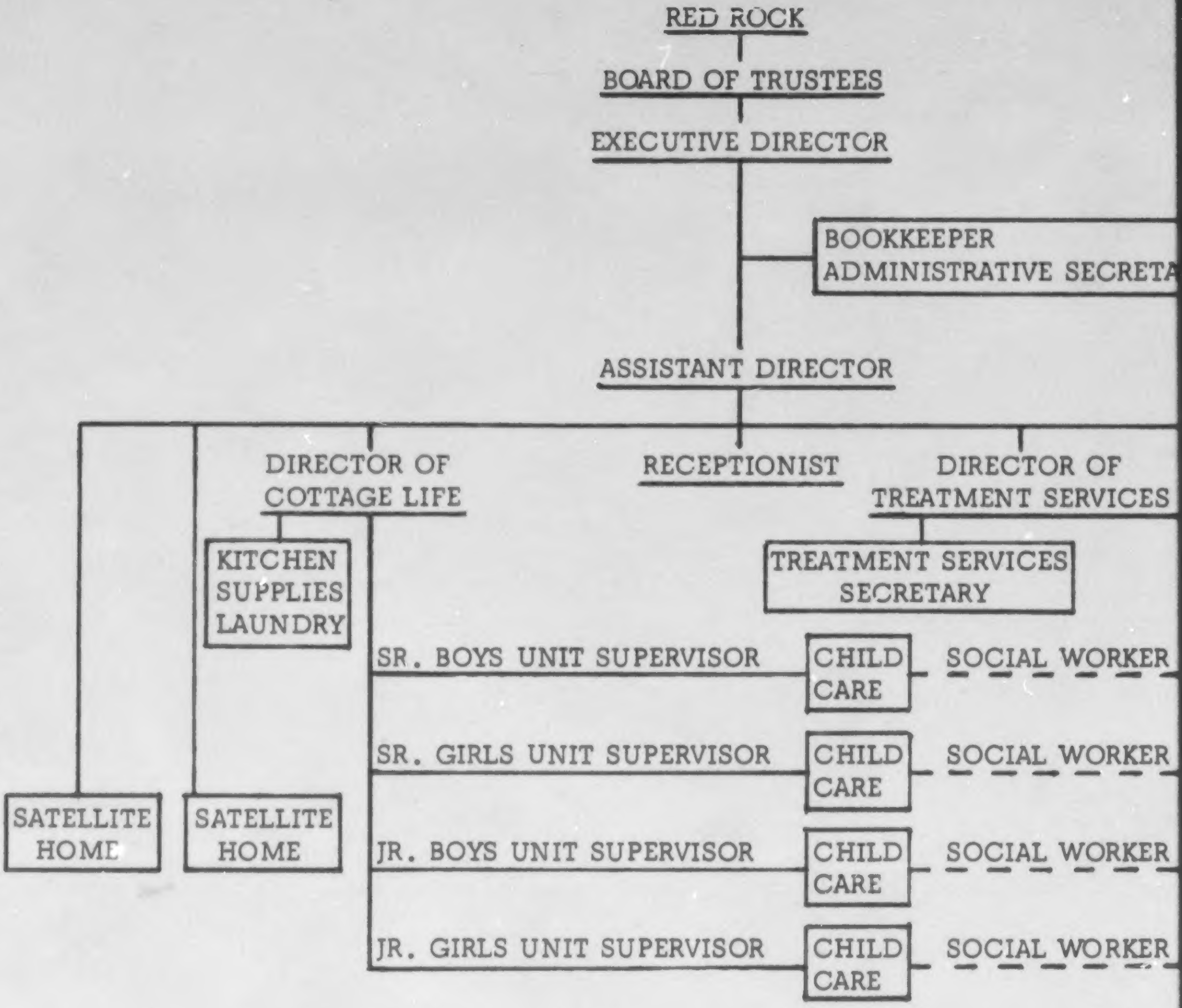
Fifteen weeks after the workshop, a team devised an experimental method for involving parents in the treatment process. They developed this process, within the new design, as a way to help them meet their responsibility for children's progress toward goals that would support their successful return to their families.

At this point the program model was formalized in a working paper, Figure II. The first sheet diagrams the reporting relationships for the four autonomous treatment teams, and the management structure of the support services as well. The next two sheets define the jobs in the treatment program in terms of the responsibilities they have accepted. The last sheet shows the schedule of standard meetings established to maintain the program. The working paper only represents the program as it had progressed through 4 months. Shortly after it had been issued, the social workers changed their assignments so each individual would be the member of one team, a move intended to further each team's working independence and to allow each social worker to build an identity with a team.

The last month of the consultation was devoted to implementing a mechanism for an ongoing self-evaluation and improvement process in the treatment program, to allow for its continual growth. This was done by setting aside a day-long session for reviewing the progress that Red Rock had made in the 6 months of the model treatment program and for planning future goals that the staff wanted to move toward themselves in the next step without support of consultation. After reviewing the progress that had been made, the problems encountered, and the lessons learned, the staff set future goals for themselves in the areas of personal evaluations, acquisition of new people, and in-service training. Finally, they designed a session 4 months later for a similar review and planning cycle.

6. Projection

The research nature of this project invites me to anticipate the progress Red Rock will make in the months following the end of the consultation. I think the major review and planning session scheduled for October 18, 1973, will be an important event in determining the future growth of the program that we have initiated. I see the goals that the staff has set as optimistic, and I think they will find that they have only partially attained them at the time of the review. If they can learn from this first formal attempt at self-improvement and maintain their optimism, the goals they set for the next period will certainly bear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KITCHEN
SUPPLIES
LAUNDRY
TREATMENT SERVICES SECRETARY
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CHILD CARE
SOCIAL WORKER
SR. GIRLS UNIT SUPERVISOR
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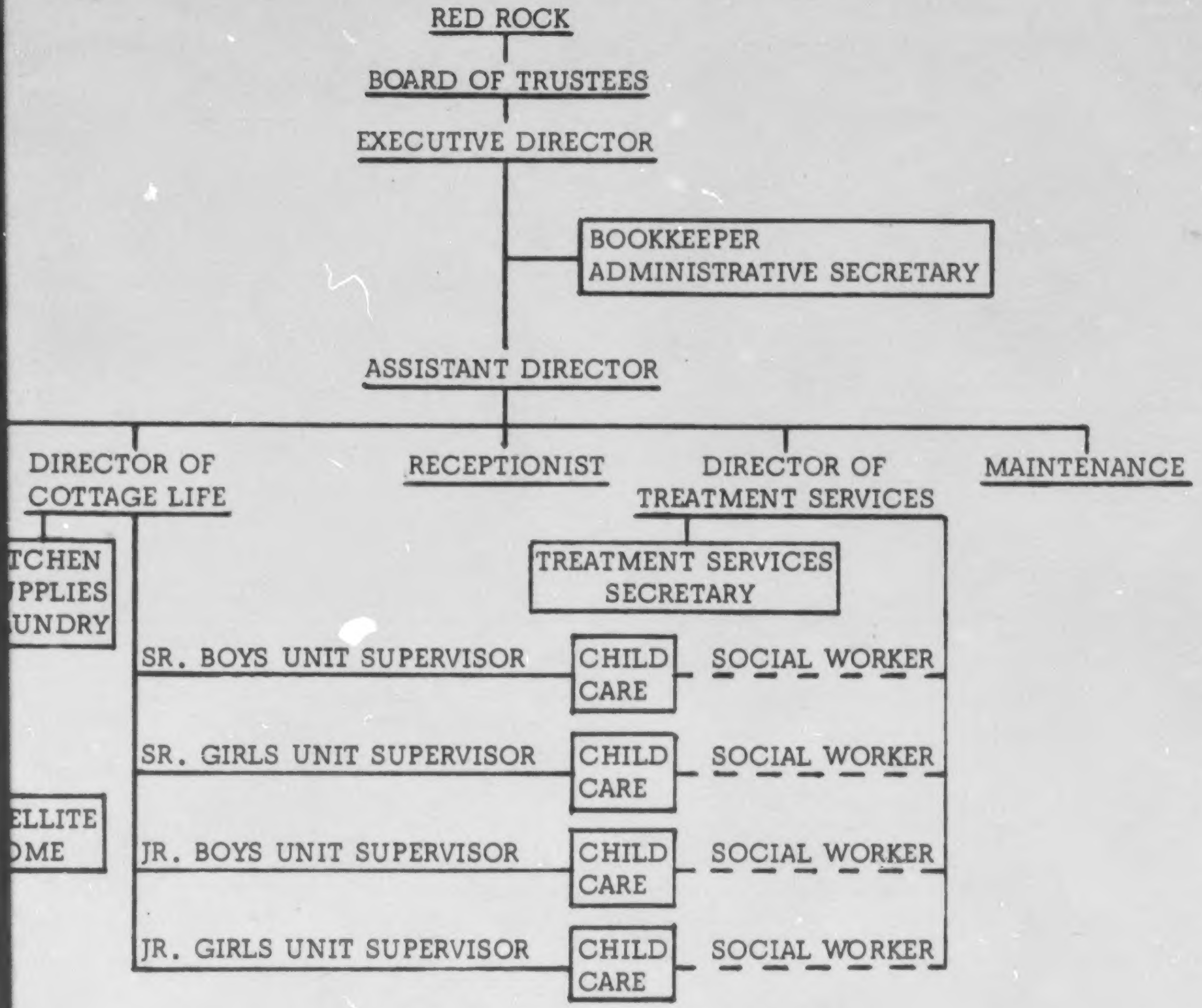
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SOCIAL WORKER

Figure II

Figure II, sheet 2

DIRECTOR OF COTTAGE LIFE

1. Responsible for hiring, firing and supervision of unit supervisor with input from social workers.
2. Overall responsibility for the quality of cottage life.
3. Responsibility for supervision of cottage support systems (kitchen supplies and laundry).
4. Administrative and program responsibilities as delegated by assistant director.
5. Shares in staff training responsibilities.
6. In conjunction with director of treatment services conduct treatment planning and progress review meetings.
7. Responsible for the coordination of unit supervisors as well as other administrative functions.

UNIT SUPERVISOR

1. Responsible for hiring, firing and supervision of child care with input from social workers.
2. Responsible for the performance of child care teams in translating treatment goals into child care functions.
3. Carry out direct child care functions.
4. Responsibility for quality of cottage life.
5. Responsibility for clothing funds and other fiscal matters related to cottage life.
6. Responsible for inservice training re: agency policy and administration of personnel policies.
7. Direct responsibilities for scheduling and approving overtime.

Figure II, sheet 3

ASSISTANT DIRECTOR

1. Overall responsibility for evaluating the treatment program.
2. Has responsibility for maintaining all aspects of campus program.
3. Has supervision responsibilities for Satellite Home.
4. Has supervision responsibilities for supportive programs (i.e., kitchen maintenance).
5. Has recruitment responsibilities for foster homes.
6. Has hiring, firing and supervision responsibilities for:
   a) cottage life supervisor
   b) chief social worker
7. Has responsibilities for initial filling of unit supervisor positions.
8. Has fiscal responsibilities as they relate to the above.
9. Has campus administrative responsibilities (PD back-up responsibilities).
10. Has project and committee tasks with the board of directors as delegated by the executive director.

DIRECTOR OF TREATMENT SERVICES

1. Supervise, hire and fire social workers.
2. Overall responsibility for the quality of the treatment program.
3. Would be responsible for covering other social work duties.
4. Would have other administrative duties as delegated by the assistant director.
5. In conjunction with the director of cottage life conduct treatment planning and progress review meetings.

SOCIAL WORKER

1. Responsible for the establishment of reasonable, measurable treatment goals for their case load.
2. Responsible for monitoring progress toward treatment goals.
3. Responsible for intake and discharges and family after care, including foster home and development.
4. Responsible for initial and ongoing evaluation of team members' ability to understand treatment goals and their ability to carry out concepts in their child caring duties.
5. Shares responsibility in staff training.
6. Responsible for specific therapy services, e.g., individual and group treatment contracting outside diagnostic and professional therapy.

Figure II, sheet 4

MEETINGS NECESSARY TO CARRY OUT RESPONSIBILITIES OF AGENCY

1) Unit Team Meetings (Weekly as previously scheduled)	Unit Supervisor Social Worker Child Care of that Unit
2) Assistant Director Staff Meeting Thursdays 1:30 to 2:30	Assistant Director Director of Treatment Services Director of Cottage Life Unit Supervisors Social Workers
3) Treatment Goals and Prog. Meetings Week #1 2-3 Jr. Boys 3-4 Sr. Girls Week #2 2-3 Jr. Girls 3-4 Sr. Boys	Director of Treament Services Unit Supervisor of Unit Social Worker of Unit Director of Cottage Life
4) Administrative Meeting Wednesdays 10-11	Executive Director Assistant Director Director of Cottage Life Director of Treatment Services
5) Unit Supervisor Meeting Tuesdays 1-2	Director of Cottage Life Unit Supervisors of Cottages

even greater fruit for them. If, however, they become discouraged with the process, they will work with the program design as it stands at that point and grow gradually dissatisfied again with themselves as a children's residential center. I hope and believe they will find the energy to continue the growth they have begun.

(A sample of the consultant's Activity Reports, written after each consultation visit, is appended at the end of the material pertaining to Red Rock.)

C. What the Independent Evaluator Reported, Based Upon His Interviews at Red Rock in November, 1973, Three Months after Completion of the Consulting Intervention

(This report was submitted by Roland Wilhelmy, PhD, the independent evaluator.)

1. Assignment

To meet with certain staff members of Red Rock, and to assess and report on the changes that had taken place there since August, 1972. The prime focus of my investigation was the impact that HIRI's consultant's actions had had, but I was also interested in all significant changes regardless of how they came about.

2. Procedure

My visit to Red Rock covered part of 2 consecutive days. I conducted a series of interviews with members of the agency staff. These included the executive director, the assistant director, the director of cottage life, the supervisor of social workers, a social worker, four unit supervisors and three child care workers. The interviews lasted 1-1 1/2 hours each. They were conducted in the individual's or group's place of work. Each interview began with three open-ended questions asking the respondents to help the interviewer list the significant events or changes, describe what led up to them and what they, in turn, might have led to. Three subsequent questions asked the respondents to state which change seemed most important, to rate the current situation and the situation in August, 1972, on a 100-point scale, and to describe ways in which the client-consultant interaction might have been strengthened. In addition to the questions just described, I had a checklist of items which, on an a priori basis, seemed to be important to investigate. Both the questions and the checklist are included here.

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3. The Interviews

I stayed fairly close to the questions listed on the first page of my interview sheets, asking questions when necessary and noting which answers I didn't have to ask for. The interviews generally were quite comfortable for me, and I think for the interviewees. The consultant and Red Rock had developed an aura of mutual trust, understanding and openness. This seemed to carry over even to me.

a. The First Three Questions

(These questions are listed in Chapter III, Overview of the Consultation Intervention.)

b. Major Events to Which I Hoped to Evoke Staff Response

Before visiting Red Rock but after reading all of the consultant's reports and after meetings with Harvey Ross, Jean Hall, Molly Lewin and the consultant for several days, I had prepared a list of events and major consultant interventions which it seemed Red Rock's staff should be able to recall in some detail. The events were:

(1) An unsuccessful attempt to reorganize the Junior Boys Unit as a more effective team, intended as a demonstration for the rest of Red Rock.

(2) A series of meetings which culminated in a complete redesigning of each person's role and responsibilities at Red Rock intended as an illustration that large scale change was both possible and profitable for those involved.

(3) The organization of child treatment teams on a basis of one team to a unit, with each team including one unit supervisor, one social worker and the child care workers in the unit, intended to facilitate more efficient treatment goal planning and more effective treatment.

c. Some Results of the Interviews

All of the people I interviewed at Red Rock were very much aware of the consultation efforts and why they were made. While the specific evaluation of the results of the consultative efforts may have varied from one individual to another, following up Question 1 with Questions 2 and 3 was not necessary. These three questions were designed with the presumption that at least some of the personnel at some of the institutions might need some careful questioning to elicit any memory of consultative events. That presumption was not valid at Red Rock. The following are responses unique to certain individuals or groups. The reader should assume that all responses reported here were given in a context of responses indicating detailed awareness of the consultant's efforts, which have been described in full in his narrative and activity reports.

d. Interview with Person #1--Important Events Recalled

Person #1 stated that he perceived the following four important events:

(1) Learning to trust the consultant. The consultation began with openness and presumed trust of the consultant--the presumption was rapidly confirmed. Person #1 said that Red Rock was very fortunate in the consultant they received. The staff was told to view the consultant as a participant-observer and not to perform for him or hide things from him. That seemed to be successfully achieved. One of the receptionist-secretaries said that the consultant had seemed to be very much part of the staff while he was there. One of the many things that clinched Person #1's trust in the consultant was a very early meeting when he sat in on a psychiatric consultation with the social workers. Apparently this was a very stormy meeting and one in which the consultant didn't interfere, although he might have been tempted to do so. Person #1 was then satisfied that the consultant was going to be worthy of trust.

(2) Appreciating the skill and role helpfulness of the consultant. At the beginning of an exercise in renegotiation of the roles and responsibilities of the Red Rock staff, the consultant demonstrated a deft touch in the sensitive renegotiations of the jobs of the executive director and assistant director. The consultant helped to merge the assistant director into Red Rock, especially at some crucial December and January meetings. Certain kinds of competition and mild feelings of trespass that had existed were reduced by negotiation.

(3) Responsibility negotiation conference at the Hilton. This was the first role and responsibility conference, held at the Hilton Hotel, where the jobs of the executive and assistant directors were negotiated. On the negative side, Person #1 felt that the consultation and renegotiations of responsibilities had taken energy away from his long range planning. It was not until

6 months after the consultation was completed that he could return to long range planning.

(4) Wrap-up conference. A wrap-up conference was held, at which the new design was analyzed and reviewed.

e. Interview with Person #2--Important Events Recalled

(1) The consultant assisted in straightening out lines of communication and in creating a much more efficient operation. He helped to pinpoint responsibilities. The consultant's orientation, a blend of human dynamics and organizational development, was exactly what Red Rock needed.

(2) Goal-setting demonstration was poorly received. Although Person #1 had used goal setting before the consultation, the consultant had set it up on an institution-wide basis. (It had appeared to all HIRI consultants that one of the apparent deficiencies of all four institutions was the lack of attention to individual goal setting for the progress of each child. HIRI offered to bring a nationally known consultant on this subject to the agencies for workshops on goal setting. All of the institutions said they were interested, and the consultant visited Red Rock in January, 1973. The reaction at this agency was not very favorable although the visit did stimulate the staff to evolve their own plan for goal setting.) The consultant's presentation was a setback. The response was negative, and goal planning became a bad term at Red Rock. People now do goal planning in their own way.

(3) The HIRI consultant's job was incomplete. The workshop (review session) originally scheduled for October, 1973, but now rescheduled for December 4 constituted a problem at Red Rock. They weren't sure how to proceed in the workshop. Also it took longer to set up criteria and procedures than they had expected. The supervisors need more help with their supervisorial roles.

(4) Relations between each treatment team and its social worker are better than ever before. Person #2 has been trying to break down the tradition that social workers deal mainly with individuals in private conferences, rather than as participants in a treatment team. This effort is not yet completely successful.

f. Interviews with the Social Workers--Important Events Recalled

(1) The establishment of restructured positions had prematurely terminated the negotiation that had gone on before. The social workers felt that there was more negotiating to do. They pointed out that since the consultant left, negotiation has occurred, but "only" in the satellite homes. (Unit staff mentioned the same event but with emphasis on the fact that people *had* learned how to negotiate.)

(2) The creation of the unit supervisor position led to the assignment of one social worker for each unit. Under the new organization everyone seemed too busy with his own work to help others in problem solving. There was not much time available for the psychiatrist to consult with the social workers on individual cases. They felt that having one social worker per unit was a mixed blessing. While the work load had been rationalized, they no longer had the easy interaction that had existed when two social workers worked together.

In their opinion, the goal-planning consultant's presentation was inappropriate. This negative reaction might have resulted in part from lack of preparation for the presentation. In their judgment, the consultant's style should have been more organized. They felt that he did not understand an "open" place like Red Rock, and that he appeared to be more accustomed to locked wards. His examples and insights did not seem to apply well to Red Rock.

(3) An effort was made to induce the social workers to move to the cottages. The unit staff wanted social workers to be in the unit with them. The assistant director agreed, but the social workers did not want the move to occur without more thought on their part about the whole matter. They felt that they had prevented the move for the moment. It seemed to them that Red Rock was approaching a decision about the move before the social workers had decided what they wanted. "Some cottages are ratty and depressing and hard to conduct [their] business in." They felt that there was mistrust of the social workers in the cottages and that the unit staff wanted to turn them into child care workers. One social worker said that, although she agreed that communication has been improved, she personally has discovered how little influence she has. Another said the social workers never have been a solidified group because of the turnover. Thus, they have never had a chance to resolve their differences and to decide to go in a particular direction. She said that the social workers felt that a male social worker was recently employed only because he was to be "groomed for administrative work."

(4) There had been improvements. On the positive side, they both agreed that things were better than they used to be. The role of the director of cottage life had become more clarified. There was definitely more involvement in treatment by the child care staff. The teams felt more like teams and there was less distrust and more understanding. Some of their current difficulties were being dealt with in the ongoing staff evaluation.

g. Interview with the Unit Supervisors--Important Events Recalled

Besides the regular intervention events, the upgrading of child care workers was important. The unit supervisors now paid considerable attention to who was hired. The consultant had made them aware of the expectations that they had regarding child care workers. Because they were clear about expectations they were no longer willing to hire mere baby sitters. Treatment was taken out of the social workers' offices and made into a cottage function.

Previously, people "worked here" but the expectations, the scope, the authority weren't defined. They were now utilizing meetings much better than before. They had agendas. Things were a lot more "up front"; problems which came up weren't suppressed; they didn't "go underground" any more.

The unit supervisors no longer slipped out of meetings and other obligations. Things happened at the meetings and people wanted to have a part in them. Since responsibilities were clear, no one wasted much time trying to shirk them. They felt that they were attending more and more meetings, but that the meetings were better. Having the meetings set up weekly on a calendar helped the staff plan their time better. The board of directors began to meet with them. They were consulted on matters, and this was not true before. People now listened to the cottage staff. The unit supervisors were also proud of the committee which evaluated psychiatric consultations.

Treatment goals were objectified and quantified. This was especially true in the Junior Girls Unit where treatment now moved faster. Children in Junior Girls Unit were directly involved in their goals. Basically goal planning and other changes were taking place more completely and more rapidly with the Junior cottages than with the Senior cottages. (Before the consultation began, the Junior and Senior units were at different degrees of development, so progress may be equal in the units.) Senior Boys Unit was "just beginning to plan." Senior Girls Unit was using goals but not expressed in the same form. (I interpret this to mean that they weren't objectified and quantified to the same degree as in Junior cottages.) The unit supervisors felt that they now had more outside community contacts and resources than they had had formerly.

The unit supervisors found that they had less time to be with kids than they had before they became supervisors. This seemed to be inevitable. Both the supervisors and the Junior Boys staff pointed out that cottages were no longer so isolated but at at the same time they were more autonomous. Units were free within their responsibilities to do whatever they chose. The assistant director and the director of cottage life no longer tended to sit in on unit meetings the way they used to. Social workers now briefed new cottage staff on procedures and goals. The unit supervisors were working towards a 40-hour week. Their week used to be 48 hours but, thanks to certain changes, they were currently working approximately 44 hours per week.

There was less tendency for a "we-versus-they" approach to arise in relationships with child care staff and the administration. There was more of a "let's-give-it-a-try" attitude. In earlier times there had been a lot of hoping that problems would go away. Now the unit supervisors felt that they should "just get off their butts" when something came up. They knew that the executive director was available to work with them.

h. Interview with Person #3--Important Events Recalled

Senior Boys Unit was encountering a problem with record keeping. They did actually have goal plans but that was not apparent from the records. "The [goal-planning] consultant's visit was weird," but most of Red Rock "bounced" from disagreements with the consultant's point of view to a constructive alternative. Pay scale for unit staff has increased commensurately with their new roles and responsibilities.

i. Interview with Group #4--Important Events Recalled

Having a live-in unit supervisor impressed the unit staff, because it provided them with direct access to the higher administrative levels. They felt much satisfaction about that.

The unit staff commented on the role and responsibility negotiation. They felt that the initial bargaining sessions begun at their level were "no great thing," but that the bargaining on an overall level was much better. It had given them a stronger organization more able to make constructive changes and to respond to emergencies. They talked of their institution of goal-planning procedures, their use of treatment goals both short-and-long-term, and of how they continued with these even though Junior Boys Unit had not had a social worker since August. The unit staff were conducting parent group sessions in the absence of the social worker. They felt that they had become "meeting conscious." Meetings were important and people would attend them now, because the meetings had consequences for them.

This group felt that things got "opened up" during the process of filling out the evaluation forms provided by HIRI. It seemed to provide a context for them to begin to talk about things among themselves. Also it was considered to be an indication that the administration wanted to become informed about the feelings of cottage staff. The Baseline Data Form initially was suspected by the unit staff. They thought it was "another one of the executive director's things."

They thought that having evaluations of the staff was important and pointed out that a committee had been set up to evaluate the psychiatric consulting work. The psychiatrist had complained that he was the only person at Red Rock who wasn't being evaluated. A committee including people at the unit level was set up to provide an evaluation for him. The committee had been formed after the consultation ended. This fact seems illustrative of the considerable learning that had taken place.

j. Additional Questions

In addition to the three basic questions (recall of all changes at Red Rock since August 1972, how they came about, and what were the results) which formed the core of the interviews, I directed the following three questions to the interviewees.

(1) Which of those changes do you think was the most important, or the most useful?

Person #1--The single most important day was the January 25, 1973, conference at the Hilton where roles were negotiated between caseworkers and child care staff.

Person #2--The best thing was the negotiation which led to the opening up of channels of communication. Everyone now understands that change is possible. People now start to take responsibility for their own decisions. They no longer "look to big daddy to fix everything" for them.

Person #3--She felt that the fact that the child care worker was now seen as the most important person in treatment was the most important thing.

Group #4--One person answered that the creation of the unit supervisor position was the most important change. Another said that the emphasis in the units was now on more than just child care; it was on treatment. Another felt that the administration of the Baseline Data Form was most significant; On a long-term basis they began a process of self-examination and self-renewal which was still continuing.

Social Workers--The most important change for them was the clarification of roles and responsibilities that developed out of the negotiations. Clarification has been followed by an increase in trust and understanding among all the staff, and also in a true team spirit in the treatment teams.

The social workers thought that the most negative change was the decrease in psychiatric consultation with them. They also felt that while supervision and responsibility were not great problems, the issue of leadership was. Leadership within the team was not clear. The supervisors looked to the social workers for leadership, and the social workers "weren't sure how much of the pie to take." The differences in styles between social worker and unit supervisor in some units had caused conflict.

(2) Using a scale on which a score of 100 would be an absolutely perfect situation and zero would indicate a disastrous failure, would you tell me how you would rate the general situation here now? How would you rate the way it was in August, 1972, (or date the person started to work here, if a later date).

Now	Then
50	35
73	64
74	51
65	45
70	40
75	35
75	40
75	40
75	45
80	45
80	40
(Mean = 72.3	(Mean = 43.6)
N = 11	N = 11

(3) Can you tell me some things that the consultant might have done here, or done differently? Can you tell me some things that Red Rock should have done differently with the consultant?

Person #1--He wished that the consulting involvement with the board had been more complete. The board never took the consultant seriously, perhaps because of its pattern of suspicion of outsiders and its anti-confrontational approach to matters before it. In addition, the board had spent much of its time on financial matters. With the arrival of a new controller who provided financial reports which the board trusted, it had more time to deal with other things.

Person #2--He wished the consultant had worked more with the board. He felt that the board had the financial resources to improve the physical plant right away, but was unwilling to do so.

Unit Supervisors--"Should have spent more time in the Senior Girls cottage." The staff had not known who the consultant was in the beginning and did not understand why he was there until later. They wished that the consultant had helped them carry to completion their review and stock-taking meeting which was to take place 6 months after he had left.

Social Workers--They felt that the consultant should have spent more time with the cottage staff, should have included them in the first meeting. Everyone needed to practice things more with the consultant, particularly negotiations. Although they learned the general idea, they didn't have a chance to practice as much as they would have liked. Similarly, they would have preferred more practice with goal planning. They also would have appreciated more direct consultation with the social workers in order to review and clarify their role and the extent of their authority within the agency. They felt that the consultant was caught between houseparents and social workers.

Group #4--The consultant should have sought to involve all of the staff from the beginning rather than starting at the high administrative level and working down. At the unit level, no one knew what the consultant was supposed to be doing. Therefore, they started out feeling negative towards him. They felt that he should have explained his purpose more explicitly. They also felt that as houseparents they might have made better use of the opportunity for team development that the consultant did offer to them in the beginning.

4. Report of Issues of A Priori Interest

Besides the questions that I asked each interviewee, I had a list of items about which I wanted to form an opinion. The items, listed below, are formulated as questions directed to myself. Sometimes I would be able to answer the questions without asking anyone additional questions; at other times, I would ask certain questions designed to help me formulate answers to my questions.

Is each child dealt with by a team, one which has a set of goals for the child and a reasonable, unified understanding of how each member of the team is to help the child to achieve these goals? There was an effort to coordinate in each unit a treatment team working toward coherent, unified, and preset goals. The effort had led to moderate success in the Senior Boys and Senior Girls Units. In the Junior Boys and Junior Girls Units progress was more advanced; treatment teams worked with parents, and with the children in establishing and carrying out procedures leading to achievement of the goals.

Communication: Where and how did the staff hear about things that affected them, such as forthcoming changes of policy, procedure and feedback on their performance? Communication generally has been quite good, and seemingly much improved since August 1972. The improvement was most marked between administration and child care staff. It was least evident between administration and social worker--although even the social workers mentioned that communication between them and the rest of the institution was improved. The executive director wants, and gets, a "whiff of the BO." The assistant director receives all of the information he needs on the treatment of the children, but not enough on the performance of the staff. Some problems still go underground.

Does everyone know what his responsibilities are and to whom he is accountable? Does he feel that he could if necessary change his responsibilities and roles to meet changing conditions? Does he feel that others could change their roles and responsibilities as well? Does everyone have an understanding of the relatedness of all persons and activities to goals and purposes? Yes, in a word. Unit staff and unit supervisors have the best understanding of their responsibilities. The social workers and administrators are still getting the new system adjusted; they indicate that they are changing some aspects of their roles and clarifying others. Everyone does have an understanding of the relatedness of all persons and activities to the goals and purposes, but there remains conflict between social workers and the rest of the institution over what the social workers' actions should be in carrying out the goals.

Purpose of the institution: treatment or custodial care, management by objective, management by crisis? I met no one who indicated that the purpose of the institution was custodial care. Within limitations due to the newness of goal planning to the institution as a whole, there was a concerted effort by everyone to plan ahead, to set goals and to anticipate changes.

With respect to child care I found treatment planning with long- and short-term goals was prevalent in the Junior unit. Some elements of goal planning were present in the Senior units, but the goals in Senior Girls Unit were not objective ones and the goals in Senior Boys Unit were not recorded.

Do the social workers participate in unit activities with children and the child care staff? Junior Boys Unit had had no social worker since August. A social worker who had been selected and was to have started December 1, 1973, dropped out at the last moment. The social worker in Junior Girls Unit does participate considerably in unit activities, but the social workers who deal with the Senior Units seem to resist being identified too much with child care.

Did a second satellite home get established? How did the board of directors handle the matter? Was any aspect of setting up the new home derived from the consultant's interventions? The second satellite home was just established in November, 1973. The board funded it with no opposition. The social workers used negotiation procedures (a technique derived from the consultant) in setting up staffing.

A meeting to review the new roles and the planning system had been scheduled for October, 1973. Did it meet as scheduled? The meeting was deferred because Red Rock was not "ready" for the meeting. That is, not all of the reports (reviews and evaluations) were completed. The meeting was rescheduled for early December, 1973.

Is the director of cottage life satisfied with the treatment program and with her role and responsibilities? She is satisfied with the progress of the treatment program so far. She had recently been unsure of her own role and of her purposes and performance, but a meeting the day before the interview had resolved and clarified the situation for her. She and the unit supervisor understood each other's position much better following the meeting.

Is the supervisor of social workers satisfied with the rate of progress in the treatment program--overall, and with her part in it? Not fully, but possibly full satisfaction would be an impossible goal. She feels isolated from the rest of the administrative staff--neither a social worker nor an administrator although she fills both roles. She feels that the administration is grooming a recently hired male social worker for an administrative post. She does see progress in the treatment program and increased clarity of issues and purposes as having resulted from the consultation.

What are the child care workers' views of any changes? They see things changing for the better (in Junior Boys Unit, at least). They are consulted by the administration about things that affect them and they provide consultation and feedback to others as well. Generally the child care workers and the unit supervisors appear to have benefited most from the consultation.

5. Summary

Was the consultation at Red Rock beneficial to staff and to the organization as a whole? Yes.

Did the consultant achieve what he set out to achieve? With a few limited exceptions, yes. Since different units were in differing stages of organization when he began consultation they tended to be at different levels after he finished. The social workers were asked to make the most profound changes in their mode of operation. Since the changes tended to conflict with their perceived professional identities, the consultant should be excused for not having transformed their roles as fully as he had once hoped.

All persons interviewed were asked to rate the general situation at Red Rock on a scale of 0-100, as of August, 1972, and again as of the time of the evaluation. The mean scale for the earlier date was 43.6 and for the more recent date, 72.3--a statistically significant difference. These ratings came from a total of 11 respondents.

Most fundamentally, the whole of Red Rock seems now to be in a position to examine itself critically with the expectation that it can itself make the changes which may need to be made. The fact that the staff see more changes that need to be made is an indication of the consultant's success. Thus the most significant finding is not that things have already changed for the better at Red Rock but that things are likely to continue to change for the better in the future. The fact that Red Rock may have been at a point of considerable unrest in August, 1972, can account, in part, for the improved current situation, but it cannot account for the foundation that now exists for future change.

D. What Is Suggested by the Before-and-After Questionnaire Responses (BDF-ISSQ)

Below, in tabular computer printout form, are the responses of the staff at Red Rock to the 40 items on the BDF administered in 1972 compared with

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TABLE 3

ITEM RESPONSE: FORTY OLD ITEMS AND FORTY NEW ITEMS ON THE IS
RED ROCK (N = 29)
(For old items, ISSQ responses are listed first,
and 1972 BDF responses are listed immediately below them)

Response Categories: 1 = Poor; 2 = Fair; 3 = Satisfactory; 4 = Good; 5

	RESPONSE CATEGORIES									
	1		2		3		4		5	
ITEM	N	%	N	%	N	%	N	%	N	
1 ISSQ	1	3.45	4	13.79	17	58.62	6	20.69	1	3
BDF	2	10.53	2	10.53	11	57.89	3	15.79	1	5
3 ISSQ	0	0.0	4	13.79	18	62.07	3	10.34	4	13
BDF	0	0.0	7	36.84	9	47.37	3	15.79	0	0
4 ISSQ	0	0.0	3	10.34	19	65.52	4	13.79	3	10
BDF	0	0.0	5	26.32	11	57.89	3	15.79	0	0
5 ISSQ	0	0.0	4	13.79	17	58.62	5	17.24	3	10
BDF	0	0.0	7	36.84	9	47.37	3	15.79	0	0
6 ISSQ	0	0.0	7	24.14	15	51.72	6	20.69	1	3
BDF	0	0.0	5	26.32	8	42.11	5	26.32	1	5
8 ISSQ	2	6.90	7	24.14	10	34.48	8	27.59	2	6
BDF	1	5.26	4	21.05	8	42.11	5	26.32	1	5
13 ISSQ	1	3.45	4	13.79	3	10.34	12	41.38	9	31
BDF	0	0.0	3	15.79	3	15.79	8	42.11	5	26
14 ISSQ	0	0.0	5	17.24	15	51.72	7	24.14	2	6
BDF	0	0.0	4	21.05	8	42.11	5	26.32	2	10
15 ISSQ	3	10.34	3	10.34	12	41.38	9	31.03	2	6
BDF	0	0.0	5	26.32	8	42.11	4	21.05	2	10
16 ISSQ	0	0.0	5	17.24	12	41.38	8	27.59	4	13
BDF	0	0.0	4	21.05	7	36.84	6	31.58	2	10
17 ISSQ	1	3.45	5	17.24	11	37.93	9	31.03	3	10
BDF	1	5.26	2	10.53	10	52.63	4	21.05	2	10
20 ISSQ	0	0.0	5	17.24	6	20.69	12	41.38	6	20
BDF	2	10.53	3	15.79	9	47.37	5	26.32	0	0
22 ISSQ	1	3.45	6	20.69	14	48.28	6	20.69	2	6
BDF	1	5.26	4	21.05	11	57.89	2	10.53	1	5
29 ISSQ	1	3.45	5	17.24	13	44.83	7	24.14	3	10
BDF	0	0.0	1	5.26	13	68.42	5	26.32	0	0
31 ISSQ	2	6.90	4	13.79	8	27.59	9	31.03	6	20
BDF	2	10.53	2	10.53	9	47.37	5	26.32	1	5

TABLE 3

M RESPONSE: FORTY OLD ITEMS AND FORTY NEW ITEMS ON THE ISSQ AT
RED ROCK (N = 29)
(For old items, ISSQ responses are listed first,
and 1972 BDF responses are listed immediately below them)

se Categories: 1 = Poor; 2 = Fair; 3 = Satisfactory; 4 = Good; 5 = Excellent

RESPONSE CATEGORIES										MEAN RES-PONSE	N
1		2		3		4		5			
N	%	N	%	N	%	N	%	N	%		
1	3.45	4	13.79	17	58.62	6	20.69	1	3.45	3.07	29
2	10.53	2	10.53	11	57.89	3	15.79	1	5.26	2.95	19
0	0.0	4	13.79	18	62.07	3	10.34	4	13.79	3.24	29
0	0.0	7	36.84	9	47.37	3	15.79	0	0.0	2.79	19
0	0.0	3	10.34	19	65.52	4	13.79	3	10.34	3.24	29
0	0.0	5	26.32	11	57.89	3	15.79	0	0.0	2.89	19
0	0.0	4	13.79	17	58.62	5	17.24	3	10.34	3.24	29
0	0.0	7	36.84	9	47.37	3	15.79	0	0.0	2.79	19
0	0.0	7	24.14	15	51.72	6	20.69	1	3.45	3.03	29
0	0.0	5	26.32	8	42.11	5	26.32	1	5.26	3.11	19
2	6.90	7	24.14	10	34.48	8	27.59	2	6.90	3.07	29
1	5.26	[illegible]	21.05	8	42.11	5	26.32	1	5.26	3.05	19
1	3.45	[illegible]	13.79	3	10.34	12	41.38	9	31.03	3.83	29
0	0.0	3	15.79	3	15.79	8	42.11	5	[illegible].32	3.79	19
0	0.0	5	17.24	15	51.72	7	24.14	2	[illegible].90	3.21	29
0	0.0	4	21.05	8	42.11	5	26.32	2	10.53	3.26	19
3	10.34	3	10.34	12	41.38	9	31.03	2	6.90	3.14	29
0	0.0	5	26.32	8	42.11	4	21.05	2	10.53	3.16	19
0	0.0	5	17.24	12	41.38	8	27.59	4	13.79	3.38	29
0	0.0	4	21.05	7	36.84	6	31.58	2	10.53	3.32	19
1	3.45	5	17.24	11	37.93	9	31.03	3	10.34	3.28	29
1	5.26	2	10.53	10	52.63	4	21.05	2	10.53	3.21	19
0	0.0	5	17.24	6	20.69	12	41.38	6	20.69	3.66	29
2	10.53	3	15.79	9	47.37	5	26.32	0	0.0	2.89	19
1	3.45	6	20.69	14	48.28	6	20.69	2	6.90	3.07	29
1	5.26	4	21.05	11	57.89	2	10.53	1	5.26	2.83	19
1	3.45	5	17.24	13	44.83	7	24.14	3	10.34	3.21	29
0	0.0	1	5.26	13	68.42	5	26.32	0	0.0	3.21	19
2	6.90	4	13.79	8	27.59	9	31.03	6	20.69	3.45	29
2	10.53	2	10.53	9	47.37	5	26.32	1	5.26	3.05	19

Item		1 N	1 %	2 N	2 %	3 N	3 %	4 N	4 %	5 N	
32	ISSQ	2	6.90	7	24.14	13	44.83	7	24.14	0	0
	BDF	3	15.79	2	10.53	6	31.58	5	26.32	3	1
33.	ISSQ	3	10.34	3	10.34	14	48.28	7	24.14	2	6
	BDF	1	5.26	3	15.79	8	42.11	7	36.84	0	0
35	ISSQ	1	3.45	2	6.90	16	55.17	9	31.03	1	3
	BDF	1	5.26	2	10.53	8	42.11	7	36.84	1	5
36	ISSQ	5	17.24	18	62.07	5	17.24	1	3.45	0	0
	BDF	2	10.53	11	57.89	4	21.05	2	10.53	0	0
42	ISSQ	2	6.90	4	13.79	15	51.72	6	20.69	2	6
	BDF	2	10.53	11	57.89	5	26.32	1	5.26	0	0
43	ISSQ	12	41.38	13	44.83	4	13.79	0	0.0	0	0
	BDF	7	36.84	5	26.32	3	15.79	4	21.05	0	0
44	ISSQ	1	3.45	3	10.34	12	41.38	11	37.93	2	6
	BDF	0	0.0	1	5.26	6	31.58	9	47.37	3	1
45	ISSQ	5	17.24	14	48.28	8	27.59	2	6.90	0	0
	BDF	2	10.53	11	57.89	4	21.05	2	10.53	0	0
46	ISSQ	3	10.34	1	3.45	12	41.38	9	31.03	4	1
	BDF	2	10.53	3	15.79	3	15.79	8	42.11	3	1
47	ISSQ	0	0.0	5	17.24	10	34.48	11	37.93	3	1
	BDF	1	5.26	2	10.53	8	42.11	4	21.05	4	2
48	ISSQ	2	6.90	1	3.45	16	55.17	5	17.24	5	1
	BDF	2	10.53	8	42.11	3	15.79	6	31.58	0	0
49	ISSQ	1	3.45	4	13.79	14	48.28	9	31.03	1	3
	BDF	5	26.32	0	0.0	8	42.11	6	31.58	0	0
50	ISSQ	4	13.79	3	10.34	16	55.17	5	17.24	1	3
	BDF	2	10.53	4	21.05	5	26.32	7	36.84	1	5
53	ISSQ	2	6.90	4	13.79	15	51.72	8	27.59	0	0
	BDF	0	0.0	4	21.05	12	63.16	3	15.79	0	0
58	ISSQ	3	10.34	7	24.14	13	44.83	4	13.79	2	6
	BDF	4	21.05	2	10.53	8	42.11	3	15.79	2	10

Response Categories										Mean Response	N
1		2		3		4		5			
N	%	N	%	N	%	N	%	N	%		
2	6.90	7	24.14	13	44.83	7	24.14	0	0.0	2.86	29
3	15.79	2	10.53	6	31.58	5	26.32	3	15.79	3.16	19
3	10.34	3	10.34	14	48.28	7	24.14	2	6.90	3.07	29
1	5.26	3	15.79	8	42.11	7	36.84	0	0.0	3.11	19
1	3.45	2	6.90	16	55.17	9	31.03	1	3.45	3.24	29
1	5.26	2	10.53	8	42.11	7	36.84	1	5.26	3.26	19
5	17.24	18	62.07	5	17.24	1	3.45	0	0.0	2.07	29
2	10.53	11	57.89	4	21.05	2	10.53	0	0.0	2.32	19
2	6.90	4	13.79	15	51.72	6	20.69	2	6.90	3.07	29
2	10.53	11	57.89	5	26.32	1	5.26	0	0.0	2.25	19
12	41.38	13	44.83	4	13.79	0	0.0	0	0.0	1.72	29
7	36.84	5	26.32	3	15.79	4	21.05	0	0.0	2.21	19
1	3.45	3	10.34	12	41.38	11	37.93	2	6.90	3.34	29
0	0.0	1	5.26	6	31.58	9	47.37	3	15.79	3.74	19
5	17.24	14	48.28	8	27.59	2	6.90	0	0.0	2.24	29
2	10.53	11	57.89	4	21.05	2	10.53	0	0.0	2.32	19
3	10.34	1	3.45	12	41.38	9	31.03	4	13.79	3.34	29
2	10.53	3	15.79	3	15.79	8	42.11	3	15.79	3.37	19
0	0.0	5	17.24	10	34.48	11	37.93	3	10.34	3.41	29
1	5.26	2	10.53	8	42.11	4	21.05	4	21.05	3.42	19
2	6.90	1	3.45	16	55.17	5	17.24	5	17.24	3.34	29
2	10.53	8	42.11	3	15.79	6	31.58	0	0.0	2.68	19
1	3.45	4	13.79	14	48.28	9	31.03	1	3.45	3.17	29
5	26.32	0	0.0	8	42.11	6	31.58	0	0.0	2.79	19
4	13.79	3	10.34	16	55.17	5	17.24	1	3.45	2.86	29
2	10.53	4	21.05	5	26.32	7	36.84	1	5.26	3.05	19
2	6.90	4	13.79	15	51.72	8	27.59	0	0.0	3.00	29
0	0.0	4	21.05	12	63.16	3	15.79	0	0.0	2.95	19
3	10.34	7	24.14	13	44.83	4	13.79	2	6.90	2.83	29
4	21.05	2	10.53	8	42.11	3	15.79	2	10.53	2.84	19

Item		Response Categories 1 N	1 %	2 N	2 %	3 N	3 %	4 N	4 %	5 N	5
59	ISSQ	1	3.45	3	10.34	18	62.07	4	13.79	3	10
	BDF	2	10.53	2	10.53	13	68.42	2	10.53	0	0
60	ISSQ	2	6.90	1	3.45	8	27.59	12	41.38	6	20
	BDF	1	5.26	2	10.53	7	36.84	6	31.58	3	15
61	ISSQ	2	6.90	0	0.0	15	51.72	8	27.59	4	13
	BDF	1	5.26	0	0.0	6	31.58	7	36.84	5	26
62	ISSQ	0	0.0	2	6.90	16	55.17	9	31.03	2	6
	BDF	1	5.26	0	0.0	11	57.89	6	31.58	1	5
66	ISSQ	2	6.90	4	13.79	12	41.38	9	31.03	2	6
	BDF	1	5.26	7	36.84	8	42.11	2	10.53	1	5
67	ISSQ	1	3.45	5	17.24	14	48.28	7	24.14	2	6
	BDF	4	21.05	3	15.79	9	47.37	2	10.53	1	5
68	ISSQ	2	6.90	8	27.59	17	58.62	2	6.90	0	0
	BDF	2	10.53	6	31.58	5	26.32	3	15.79	3	15
70	ISSQ	1	3.45	2	6.90	14	48.28	11	37.93	1	3
	BDF	1	5.26	1	5.26	7	36.84	8	42.11	2	10
76	ISSQ	0	0.0	0	0.0	10	34.48	15	51.72	4	13
	BDF	1	5.26	4	21.05	6	31.58	6	31.58	2	10
80	ISSQ	0	0.0	0	0.0	12	41.38	13	44.83	4	13
	BDF	0	0.0	3	15.79	6	31.58	8	42.11	2	10
TOTAL	ISSQ	69	5.95	185	15.95	509	43.88	295	25.43	102	8
	BDF	57	7.50	155	20.39	303	39.87	190	25.00	55	7

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NEW ITEMS

ITEM		RESPONSE CATEGORIES 1 N	1 %	2 N	2 %	3 N	3 %	4 N	4 %	5 N	5
2	ISSQ	0	0.00	6	20.69	12	41.38	7	24.14	4	13
7	ISSQ	4	13.79	8	27.59	12	41.38	4	13.79	1	3
9	ISSQ	2	6.90	21	72.41	4	13.79	2	6.90	0	0
10	ISSQ	2	6.90	5	17.24	14	48.28	7	24.14	1	3
11	ISSQ	0	0.00	5	17.24	18	62.07	4	13.79	2	6
12	ISSQ	2	6.90	4	13.79	21	72.41	1	3.45	1	3
18	ISSQ	0	0.00	5	17.24	11	37.93	10	34.48	3	10
19	ISSQ	3	10.34	4	13.79	15	51.72	5	17.24	2	6
21	ISSQ	0	0.00	6	20.69	14	48.28	6	20.69	3	10
23	ISSQ	2	6.90	6	20.69	16	55.17	5	17.24	0	0
24	ISSQ	1	3.45	5	17.24	14	48.28	7	24.14	2	6

Response Categories

1		2		3		4		5		Mean Response	N
N	%	N	%	N	%	N	%	N	%		
1	3.45	3	10.34	18	62.07	4	13.79	3	10.34	3.17	29
2	10.53	2	10.53	13	68.42	2	10.53	0	0.0	2.79	19
2	6.90	1	3.45	8	27.59	12	41.38	6	20.69	3.66	29
1	5.26	2	10.53	7	36.84	6	31.58	3	15.79	3.42	19
2	6.90	0	0.0	15	51.72	8	27.59	4	13.79	3.41	29
1	5.26	0	0.0	6	31.58	7	36.84	5	26.32	3.79	19
0	0.0	2	6.90	16	55.17	9	31.03	2	6.90	3.38	29
1	5.26	0	0.0	11	57.89	6	31.58	1	5.26	3.32	19
2	6.90	4	13.79	12	41.38	9	31.03	2	6.90	3.17	29
1	5.26	7	36.84	8	42.11	2	10.53	1	5.26	2.74	19
1	3.45	5	17.24	14	48.28	7	24.14	2	6.90	3.14	29
4	21.05	3	15.79	9	47.37	2	10.53	1	5.26	2.63	19
2	6.90	8	27.59	17	58.62	2	6.90	0	0.0	2.66	29
2	10.53	6	31.58	5	26.32	3	15.79	3	15.79	2.95	19
1	3.45	2	6.90	14	48.28	11	37.93	1	3.45	3.31	29
1	5.26	1	5.26	7	36.84	8	42.11	2	10.53	3.47	19
0	0.0	0	0.0	10	34.48	15	51.72	4	13.79	3.79	29
1	5.26	4	21.05	6	31.58	6	31.58	2	10.53	3.21	19
0	0.0	0	0.0	12	41.38	13	44.83	4	13.79	3.72	29
0	0.0	3	15.79	6	31.58	8	42.11	2	10.53	3.47	19
69	5.95	185	15.95	509	43.88	295	25.43	102	8.79	3.15	
57	7.50	155	20.39	303	39.87	190	25.00	55	7.24	3.04	

NEW ITEMS

RESPONSE CATEGORIES

1		2		3		4		5		MEAN RES-PONSE	N
N	%	N	%	N	%	N	%	N	%		
0	0.00	6	20.69	12	41.38	7	24.14	4	13.79	3.31	29
4	13.79	8	27.59	12	41.38	4	13.79	1	3.45	2.66	29
2	6.90	21	72.41	4	13.79	2	6.90	0	0.00	2.21	29
2	6.90	5	17.24	14	48.28	7	24.14	1	3.45	3.00	29
0	0.00	5	17.24	18	62.07	4	13.79	2	6.90	3.10	29
2	6.90	4	13.79	21	72.41	1	3.45	1	3.45	2.83	29
0	0.00	5	17.24	11	37.93	10	34.48	3	10.34	3.38	29
3	10.34	4	13.79	15	51.72	5	17.24	2	6.90	2.97	29
0	0.00	6	20.69	14	48.28	6	20.69	3	10.34	3.21	29
2	6.90	6	20.69	16	55.17	5	17.24	0	0.00	2.83	29
1	3.45	5	17.24	14	48.28	7	24.14	2	6.90	3.14	29

Item		Response Categories 1 N	%	2 N	%	3 N	%	4 N	%	5 N	
25	ISSQ	1	3.45	3	10.34	16	55.17	8	27.59	1	3.
26	ISSQ	1	3.45	4	13.79	17	58.62	6	20.69	1	3.
27	ISSQ	2	6.90	4	13.79	18	62.07	5	17.24	0	0.
28	ISSQ	4	13.79	7	24.14	12	41.38	5	17.24	1	3.
30	ISSO	2	6.90	5	17.24	12	41.38	7	24.14	3	10.
34	ISSO	3	10.34	3	10.34	16	55.17	7	24.14	0	0.
37	ISSO	2	6.90	4	13.79	18	62.07	4	13.79	1	3.
38	ISSQ	1	3.45	2	6.90	10	34.48	10	34.48	6	20.
39	ISSQ	0	0.00	5	17.24	16	55.17	6	20.69	2	6.
40	ISSQ	1	3.45	7	24.14	13	44.83	7	24.14	1	3.
41	ISSQ	1	3.45	7	24.14	14	48.28	6	20.69	1	3.
51	ISSQ	4	13.79	19	65.52	5	17.24	0	0.00	1	3.
52	ISSQ	4	13.79	7	24.14	13	44.83	2	6.90	3	10.
54	ISSQ	1	3.45	9	31.03	11	37.93	7	24.14	1	3.
55	ISSQ	2	6.90	2	6.90	13	44.83	10	34.48	2	6.
56	ISSQ	0	0.00	2	6.90	7	24.14	16	55.17	4	13.
57	ISSQ	0	0.00	2	6.90	5	17.24	20	68.97	2	6.
63	ISSQ	0	0.00	4	13.79	12	41.38	10	34.48	3	10.
64	ISSQ	1	3.45	2	6.90	20	68.97	5	17.24	1	3.
65	ISSQ	1	3.45	6	20.69	11	37.93	10	34.48	1	3.
69	ISSQ	0	0.00	1	3.45	26	89.66	2	6.90	0	0.
71	ISSQ	1	3.45	3	10.34	15	51.72	8	27.59	2	6.
72	ISSQ	1	3.45	0	0.00	22	75.86	4	13.79	2	6.
73	ISSQ	2	6.90	2	6.90	18	62.07	5	17.24	2	6.
74	ISSO	6	20.69	3	10.34	13	44.83	7	24.14	0	0.
75	ISSO	2	6.90	1	3.45	1	3.45	14	48.28	11	37.
77	ISSO	0	0.00	5	17.24	14	48.28	8	27.59	2	6.
78	ISSQ	2	6.90	8	27.59	11	37.93	5	17.24	3	10.
79	ISSO	3	10.34	2	6.90	16	55.17	6	20.69	2	6.
TOTAL	NEW	64	5.52	204	17.59	546	47.07	268	23.10	78	6.
	ALL	133	5.73	389	16.77	1055	45.47	563	24.27	180	7.

Response Categories										Mean	
1		2		3		4		5		Res-ponse	N
N	%	N	%	N	%	N	%	N	%		
1	3.45	3	10.34	16	55.17	8	27.59	1	3.45	3.17	29
1	3.45	4	13.79	17	58.62	6	20.69	1	3.45	3.07	29
2	6.90	4	13.79	18	62.07	5	17.24	0	0.00	2.90	29
4	13.79	7	24.14	12	41.38	5	17.24	1	3.45	2.72	29
2	6.90	5	17.24	12	41.38	7	24.14	3	10.34	3.14	29
3	10.34	3	10.34	16	55.17	7	24.14	0	0.00	2.93	29
2	6.90	4	13.79	18	62.07	4	13.79	1	3.45	2.93	29
1	3.45	2	6.90	10	34.48	10	34.48	6	20.69	3.62	29
0	0.00	5	17.24	16	55.17	6	20.69	2	6.90	3.17	29
1	3.45	7	24.14	13	44.83	7	24.14	1	3.45	3.00	29
1	3.45	7	24.14	14	48.28	6	20.69	1	3.45	2.97	29
4	13.79	19	65.52	5	17.24	0	0.00	1	3.45	2.14	29
4	13.79	7	24.14	13	44.83	2	6.90	3	10.34	2.76	29
1	3.45	9	31.03	11	37.93	7	24.14	1	3.45	2.93	29
2	6.90	2	6.90	13	44.83	10	34.48	2	6.90	3.28	29
0	0.00	2	6.90	7	24.14	16	55.17	4	13.79	3.76	29
0	0.00	2	6.90	5	17.24	20	68.97	2	6.90	3.76	29
0	0.00	4	13.79	12	41.38	10	34.48	3	10.34	3.41	29
1	3.45	2	6.90	20	68.97	5	17.24	1	3.45	3.10	29
1	3.45	6	20.69	11	37.93	10	34.48	1	3.45	3.14	29
0	0.00	1	3.45	26	89.66	2	6.90	0	0.00	3.03	29
1	3.45	3	10.34	15	51.72	8	27.59	2	6.90	3.24	29
1	3.45	0	0.00	22	75.86	4	13.79	2	6.90	3.21	29
2	6.90	2	6.90	18	62.07	5	17.24	2	6.90	3.10	29
6	20.69	3	10.34	13	44.83	7	24.14	0	0.00	2.72	29
2	6.90	1	3.45	1	3.45	14	48.28	11	37.93	4.07	29
0	0.00	5	17.24	14	48.28	8	27.59	2	6.90	3.24	29
2	6.90	8	27.59	11	37.93	5	17.24	3	10.34	2.97	29
3	10.34	2	6.90	16	55.17	6	20.69	2	6.90	3.07	29
4	5.52	204	17.59	546	47.07	268	23.10	78	6.72	3.08	
3	5.73	389	16.77	1055	45.47	563	24.27	180	7.76	3.12	

staff response to those same items on the ISSQ in 1973. At the end of this listing are total scores for the Red Rock staff on the 1972 BDF compared with the 1973 ISSQ.

The second section of Table 3 (NEW ITEMS) lists the response of the staff at Red Rock to new items on the ISSQ which were not included in the BDF. At the end of this section are the total scores for the institution's staff on the 40 new items exclusive to the ISSQ. In addition, total scores for the staff on all 80 ISSQ items are given.

First, to discuss how the table is to be read: Let us take item #1 among the 40 old items, "Quality of intake procedures...." Out of a total number (N = 29) of respondents from Red Rock on the 1973 ISSQ, 3.45% rated Red Rock on this item as 1 (Poor); 12.79% gave a rating of 2 (Fair); 62.07% gave a rating of 3 (Satisfactory); 10.34% gave a rating of 4 (Good); and 13.79% gave a rating of 5 (Excellent). And so for each item.

The 1972 responses to the BDF for those questions are listed immediately below the ISSQ responses and are to be read in exactly the same way.

On an overall basis, 16.79% of the respondents from Red Rock gave their institution a mean rating of 5 (Excellent) on these 40 ISSQ items, compared with 10.53% for the BDF in 1972--a gain of 6.25%. With regard to specific items, scores on the 1973 ISSQ were higher than the 1972 BDF items in 21 out of the 40, were lower in 18, and one was a tie. Various types of special comparisons might be of interest to the Red Rock staff; e.g., on some items, such as numbers 20, 42, and 48, the improvement in ISSQ scores over BDF scores was significantly marked; in some instances such as item 43 (Systematic followup of the child after discharge) the score was quite low (2.21) on the BDF and even lower (1.72) on the ISSQ; the staff might well want to address themselves to this matter.

For the 40 items on which direct comparisons can be made, the mean on the 1972 BDF was 3.04 compared with the mean on the ISSQ of 3.15--an insignificant difference.

A more detailed analysis of responses on the ISSQ has been sent in a separate letter to each institution that turned in their data for this study. Also, further analysis of the ISSQ data is presented in Chapter IV of this report.

E. Commentary by Edward M. Glaser, PhD, Project Director, on the Red Rock Consultation Intervention

In the consultant's (Tom Hallam's) Overview statement, he observes: "The most important characteristic I found was a strong feeling on the part of the staff at all levels, from child care workers to the executive director, that they were capable of doing a much better job and were clearly dissatisfied with their current level of functioning." This represents a spirit and climate of creative discontent that augurs well for the possibility of progressive change if the director is nondefensive and open to it. In this case, the director was not only open to change, but was himself a "member of the club" that felt dissatisfied with the current level of functioning. He welcomed and encouraged creative ideas for improvement. Thus, as the consultant noted, "This was certainly an opportune time to begin the organizational consultation."

The consultant describes his theoretical orientation as a "systems approach." In this commentator's view, the key to his success is not in his particular theoretical orientation but rather in the attitudinal orientation expressed when he says, "...During the early weeks of the consultation, I truly had no personal agenda as I observed the organization in action, and I believe that this conveyed to the staff my respect for the job they were currently doing, as well as my interest in learning from them before attempting to teach them." Utterly sincere--and thus beautiful as a way for a consultant to build a trustful relationship!

He then proceeded in ways that were natural for him and relevant for his clients. He began to work intensively with one treatment team for the purpose of helping this team develop into a pilot demonstration model, and he used his training and experience in a systems approach to management to review--at the director's request--the institution's management systems.

If a person with, say, an orientation growing out of a clinical psychology background had been assigned to Red Rock, he probably would have focused on somewhat different problems and probably would not have tried to develop a pilot demonstration model. However, if his attitudinal orientation (heart) were truly similar to the one expressed (and acted out) by Tom Hallam, and if he had the perspicacity (head) equal to Tom's, then in the kind of "readiness" situation that characterized Red Rock at the time the consultation began, many different seeds of theoretical orientation might well have matured into good harvest.

A related key factor in this consulting intervention was the consultant's ability to learn from experiences that did not work out well, or as planned/hoped. For example: "In retrospect I can see ways in which I could have led the group more effectively, but the important lesson for me was the need to provide for the needs of individuals and groups as well as the global organization improvement strategy. I met with them again in their weekly meeting to restore my role of interested observer, but never again pursued the idea of a pilot program."

Hallam then moved to joint planning of the consultation effort by asking for help from the executive director and assistant director. With that kind of help and personalized commitment from within, and with this kind of partnership gradually extended downward to the entire staff, they co-opted each other in a very constructive sense. Thus, when the 1-day workshop was proposed as a process for developing a new organization by defining new roles and responsibilities for the staff, all concerned were ready for such an unusual exercise and experience.

All the available evidence suggests that this consultation on the whole turned out constructively and well from the perspective of all parties concerned, despite specific criticisms and suggestions about how it might have been better. While the basic reasons seem to be similar to those summarized for LCCH, there appears to be one major difference, namely, as the independent evaluator has noted, "Red Rock may have been at a considerable point of unrest (more so than LCCH) in August,1972 (when the HIRI consultation started)." But again, this was creative discontent; active concern about taking stock to see where they were, what changes or improvements seemed needed, the alternatives for bringing about progress in consensually supported ways, and active, nondefensive involvement by the director with the staff in pursuit of excellence. Thus, HIRI was able to contribute to a healthy Zeitgeist for change at Red Rock and help the staff improve their problem-solving skills. The fact that the consultation began at a time when Red Rock felt troubled constituted an opportunity to make an important contribution to trouble-reduction. Thus, as at LCCH there was a large degree of readiness for the knowledgeable and sensitively attuned outside help. The consultant offered those qualities and the Red Rock director set a role-model of personal openness, trust of and support for the consulting input.

ACTIVITY REPORT - RED ROCK

Tom Hallam August 11, 1972

Summary

This day began with a short meeting with A. Then as we had planned last week, Jean and I had discussions first with the Cottage Coordinators (B and C) and then with the Social Workers (D, E, and F). After lunch we visited the Satellite Home and talked with the Senior Care Supervisor (G) as well as several of the boys. We concluded the day with another meeting with A.

Strategy

My principal objective continues to be one of building relationships and getting generally oriented to Red Rock and children's residential institutions. I am beginning to bring in one of the major structural elements of the intervention, which is the definition of basic and specific objectives for Red Rock by the Board, administration, staff and residents. Beyond collecting data on present perceptions of objectives, I am asking people to begin thinking more broadly about what the objectives could be. I am seeking, in open systems terms, to have them define Red Rock's distinctive competence and its core processes. This will eventually form a basis for the people to analyze and define appropriate roles, and, for the staff to design jobs which optimize Red Rock's and their own objectives. It will also allow them to look outward to the environment and identify opportunities constraints, and threats, and develop suitable strategies for dealing with them.

The discussion with the Cottage Coordinators yielded agreement that the heart of the "rehabilitation" process is that the kids learn to deal with reality. They told a fascinating story of an unplanned event which provided that kind of growth: Two baby birds were found fallen from a nest on campus. Some of the children tried to return them to the nest, but repeatedly the mother threw the babies out. One of the baby birds was killed by a dog, and the other was nursed around the clock (with the night watchman making the late night feedings) until it grew up. A group then released it in the LA Zoo, where food and water would be readily available. Kids actively questioned the parent's reasons for rejecting the child, saw the need for outside help, discussed the demise of the first bird as a consequence of trying to leave before it was ready, and saw the growth and departure of the other bird as a successful rehabilitation process. The Cottage Coordinators saw the home and society as some of the important realities the children need to deal with.

The Social Workers had less to say initially about the objectives of Red Rock, but described their own contribution in some detail. They have responsibility for individual treatment plans as well as for the general treatment effectiveness of the institution. They are also primarily responsible for placement decisions, with inputs from the care staff (which also retains veto rights).

At the Satellite Home we had an unplanned opportunity to talk with a group of children. After giving us a tour of the Home (which is, incidentally, very impressive and well suited to its present use) they sat and discussed our work, themselves and Red Rock. We talked about how they were selected for the Satellite Home, their relations with new neighbors, and with the kids back at the Red Rock campus.

Our meeting with A accomplished two items. First, we clarified our proposed activities during his coming 3-week vacation. Second, we exchanged statements of Red Rock objectives as a beginning for the development of the element of the strategy. A provided the official statement of purposes from the articles of incorporation, and I gave him a draft which I had previously prepared.

Comments

- The contract psychiatrist will function as a staff consultant and will no longer be directly involved in therapy.
- Eight years ago the Home was 90% probation.
- Board is strongly oriented toward fiscal matters.
- Focus of rehabilitation is child and family.
- About 40% are leased to their own homes, 40% to foster facilities.
- Neglect of physical maintenance may represent staff "acting out."
- Need to discuss our introduction to staff next week.
- Find out more about voluntary boards in general.

THE CHILDREN'S TREATMENT UNIT, SOUTHSIDE STATE HOSPITAL

A. Summary Description of the Institution

The Children's Treatment Unit of Southside State Hospital is one of two such units located in the state. It provides residential psychiatric hospital services for boys and girls, aged 3 through 15, whose parents reside in 16 counties.

Begun in 1950, the Children's Treatment Unit has always been part of the larger Southside State Hospital which was opened in 1937. At the time of consultation, the unit, although a portion of Southside State Hospital, in many ways had remarkable autonomy, isolation, and relatively little interaction with the larger hospital.

In 1972 there were approximately 160 patients in residence, cared for by a staff of approximately the same size.

Since 1952, the unit had been headed by a child psychiatrist with an essentially psychoanalytic orientation. As with most other state hospitals, in earlier years, various subsections had been headed by physicians or psychiatrists, but such leadership has changed in the last few years. In 1972, the Children's Unit was divided into nine separate subprograms, each program with a specified population, therapeutic aim, and generally therapeutic modality. A program coordinator headed each treatment team; in August of 1972, three were led by physicians, five by psychologists and one by a social worker. In addition, there was a school for the patients headed by a principal with some 22 teachers and a related speech therapy department. The staff of the Children's Unit, consisting of some 160 persons, seemed to be almost equally represented by each of the decades (the 20s, the 30s, the 40s, etc.), with a number of the higher level positions being occupied by persons aged 60 or more.

The Children's Unit has initiated an innovative program to train college students to become professional child care specialists. Approximately 60 students commit themselves to a 2-year program which is designed to award them a master's degree and a teaching credential, both granted by a nearby college. However, the degrees available are A.A., B.A. and M.A. The A.A. is conferred by another local college. The program now consists of half-time clinical training, with clinical exposure to mentally ill children under the guidance of a skilled professional person plus approximately 10 hours of classroom work, seminars, and discussion.

Upon completion of training, graduates from the A.A. program may be hired as child care practitioners within the Children's Unit program. Graduates with a B.A. generally will seek employment in probation offices. Many of the M.A.s have been hired as teachers within the children's program and in community schools.

B. What the Consultant Thought He Was Trying to Do at the Children's Treatment Unit

(The following statement of objectives, perceptions and strategies of consultation was prepared by the HIRI consultant to this particular institution, Andrew Morrison, PhD.)

1. Overview

In 1972, at the outset of consultation, the Children's Treatment Unit seemed to be a troubled, divided, possibly declining organization. The significant difficulties that were facing the unit at this time included: a decreasing number of applications for admission, cumbersome personnel procedures which made the rapid recruitment of adequate staff difficult, relatively high turnover among younger persons holding the position of program coordinator or assistant program coordinator, the necessity of adapting to a new management procedure mandated by state headquarters--implementation of which was to have occurred in June of 1972--the fear and recognition that forces were at work to close down the entire state hospital system, theoretical differences between staff members that led to disagreement, and, finally, the uncertainty about whether the director of the Children's Unit would retire at a certain age in May of 1973. In spite of these significant difficulties, the Children's Treatment Unit rightfully was considered the best such sizable residential care facility operated by the state, possibly the best of any duration west of the Mississippi. Significant improvements had occurred in the past two decades, and yet many of the employees seemed weary, cautious, and living with widespread, relatively low morale.

2. This Consultant's Perspective Vis-á-Vis Organization

My approach to assisting in the improvement of the organization's functioning is based to a large extent upon a Gestalt viewpoint. I have been immensely impressed with the work of Kurt Lewin, Paul Schilder, and Douglas McGregor. Within this Gestalt viewpoint, I conceive of the organization as having a balanced and yet shifting stability that marks off various degrees of institutional health. Some organizations are very troubled, and I will need to work quickly, deftly, and forcefully to assist their survival. Other organizations are untuned, inefficient, and I can be a bit more vigorous, prodding, without serious risk. Yet again, some organizations are alert, efficient, aware that they are not perfect, and are actively seeking new ideas; such organizations are demanding, rapid moving, and really keep me on my toes. In any case, however, if I am going to be influential to the institution I must be seen as a beneficial force, a force that will alter the current balance within the existing network of forces. Thus, I must be visible, potent, and relatively significant. How the consultant is perceived as a new force affects the homeostatic balance of the organization.

Another aspect of my perspective is that I must be careful of my own assumptions about the nature of the organization, and conscious of my assumptions, hold them tentatively, be prepared to discover that there is a greater complexity than initially meets my eye. Thus, during the period of initial assessment I do not have distinctly clear goals or procedures, but rather, make the effort to meet people and become known so that as soon as possible I can sense the character of the organization. Again, I have rarely found that the leaders or members of an organization diagnose their troubles with precision and completeness, although many members of an organization seem certain in their perception of the situation.

Generally speaking, the larger the group, the longer the time spent in the initial assessment. As I proceed in this assessment phase, I generally batch my observations under these eight headings:

a. The degree of apparent stress observable.

b. Breadth of relevant information and the integration of such which leads to more or less effective and efficient behavior.

c. My assessment of current morale and recent changes in the level of morale.

d. The degree of planning that seems present.

e. The degree of communication within parts of the organization.

f. The degree of openness to information from outside the subgroup, outside the organization.

g. The awareness of the choice between a clearly described quality level for which the organization is striving, and the scope of activities engaged in, since an emphasis on either quality or scope reduces attention to the other factor.

h. The clarity and integration of the value system that seems to guide the organization in its relationships.

After the initial assessment phase, I generally summarize my observations verbally to the key man and (if he is willing) simultaneously to a number of the staff. Most generally, my observations are welcomed, and this then leads to a discussion concerning priorities, methods of implementing changes, etc.

3. The Year's Consultation Experience at the Children's Treatment Unit

I was actively involved at the Children's Unit from August of 1972 to early June of 1973. These 11 months proved to be most difficult, requiring from me perserverance, flexibility, and dedication. In the sections which follow I give an accounting, generally in chronological order.

The initial contact between our consulting agency and the key man at the Children's Treatment Unit was long distance, somewhat second hand, and proved a source of difficulty. The agreement to participate in the consultation was (because of extraneous circumstances) not made by the director himself but by two staff persons to whom he delegated the decision. The degree of understanding and communication between our consulting staff and the Children's Treatment Unit thus was thin, second hand, subject to all of the problems of summary and translation.

When I first arrived in August at the Children's Treatment Unit, the director was gracious, attentive, willing for me to visit the organization, but he himself wished to take a distinctly neutral, "hands off" attitude. This attitude led to our initial agreement that I would study the institution, largely from an "anthropological" point of view, and during the subsequent months I would also attempt to be as helpful to the organization as possible.

In order to more clearly assist the reader to anticipate how events unfolded, I can place certain phases with certain clear activities. They are as follows:

• August and September, 1972	Getting acquainted, assessment.
• October	Hiatus as I searched for a suitable strategy.
• November and December	The teaching of problem identification and problem solving.

January and February, 1973	A futile attempt at goal setting.
March	Review of and revision of intake procedures.
April and May	Maintaining morale.
June	Building a relationship to the new director.

The first 2 months of my consultation consisted of observing workers in action, the activities of the Children's Unit, and interviewing in considerable detail seven program coordinators, the school principal and the head of the Speech Department. After interviewing these nine key persons I concluded that the organization was indeed a troubled one, quite fragmented with low morale, considerable irritability and marked suspiciousness and fearfulness. My impression of the Children's Treatment Unit was as follows:

Stress	Moderate
Adequate information and integration	Low
Morale	Low
Communication between parts	Low
Planfulness	Very low
Openness to ideas	Very low
Degree of balance between quality and scope	Very low
Ethical standards, a coherent integrated value system	Low

Here was a large, clearly valuable children's treatment center but one in which many of the members seemed fearful, reluctant to share their views with others, especially the key man. The director had indicated that he wished to be neutral, yet many of the sorely needed changes would require his understanding and participation. I puzzled and discussed the situation with other HIRI team members. Finally we agreed in the research team that we should meet with a number of second level persons, present my observations, and see what planning and agreement could be arrived at.

Thus, in late October a meeting was held with seven of the most receptive, the most flexible leaders of the ten subunits within the Children's Treatment Center. The main gist of my observations was that the Children's Unit seemed to be composed of a number of quite isolated "mini hospitals," each of which often had a good idea, an innovative and successful practice, but as a result of low interaction between the various programs such good ideas were rarely being implemented rapidly throughout the Children's Unit. Additionally there seemed to be a distinct blockage of children when ready to leave the institution as a result of shortages of adequate residences. There also seemed to be inadequate coordination between the Children's Treatment Unit and various community resources and agencies. The various representatives at this October meeting listened to my observations, agreed most were valid, and yet there was considerable inertia in conceiving goals and methods by which the institution could be improved. By the end of the meeting we had obtained general agreement that four program leaders and the school principal would work with me in an attempt to build a more cohesive, more communicative organization. Our method of attaining this goal was to systematically identify problems, establish priorities and initiate participative problem-solving sessions. Although not by any means a new technique, the staff seemed to have no familiarity with the procedure and little enthusiasm.

November and December of 1972 were filled with weekly meetings during which I taught the key program coordinators and the school principal how to hold a problem-identification meeting, how to establish priorities within their group, how to hold problem-solving sessions. Of the various leaders present, only three felt their work groups were ready for this procedure; others reported work overloads, grave personnel problems, shortages of staff, etc. It had been my hope that the procedure would be clear, the program coordinators would grasp the method and, with my assistance or leadership, conduct problem-identification sessions within their units, later to be followed by problem-solving sessions. It had been my hope also that the individual units would discover they had many mutual problems, problems of considerable priority, problems which would yield best to concerted problem-solving activities. As the matter indeed turned out, however, in-depth problem-identification-and-solving sessions were held only with the speech department and the school. An attempt to hold a problem-solving session with one treatment unit encountered difficulties impossible to overcome. Also within this period of time, there was a shifting of leaders within the programs.

As part of the general consultation plan, the Human Interaction Research Institute proposed the idea of making an outside consultant on goal setting available to the four institutions to which we afforded consultation. This consultant works with Dr. Peter Houts at the Pennsylvania State University Medical School in Hershey, Pennsylvania; both Dr. Houts and the consultant are nationally known figures in goal-setting procedures. Since the Children's Treatment Unit had been mandated to set clear individual treatment goals for each child and each unit, such an input seemed both logical and timely. The consultant visited the Children's Treatment Unit on January 31, 1973. His 1-day workshop in goal setting was attended by at most 30 of the some 160 staff members of the Children's Unit. Additionally, a number of those present at the morning session were not present at the afternoon segment, and vice versa, for a number of reasons. One reason was the immense backlog of paperwork the staff needed to finish in order to meet a California State Department of Mental Hygiene deadline to write individual goals for each child; a second reason was the consultant's presentation itself, which was both much too simple and elementary for those who were relatively skilled in the procedure, yet a bit too cumbersome and lightly presented for those who were true novices. Thus, what could have been a considerable impetus toward clarification proved to be more of a distraction.

During these 2 months of January and February our group of key leaders was attempting to tackle the problem of the initial diagnostic procedure which all agreed was excessively time consuming, held too late after admission and was generally ineffective and inefficient. In an attempt to get the participants to focus on this initial stage of data collection and goal setting with a new patient, the split between the behavior modification therapists and the more psychoanalytically inclined therapists proved to be too wide to be bridged. The behavior modification persons saw clearly the task at hand, were eager to revise the procedure--generally wholesale--whereas the person responsible for this diagnostic procedure was much more impressed with the necessity for lengthy personal interactions by a well-trained diagnostician. Our attempts floundered on detail, and generally ended in acknowledged discouragement that we had not made progress.

March of 1973 found our group still attempting to bring the initial assessment session to some level of efficiency and effectiveness that the group could be proud of. Rather than being able to state a goal, much of the group's activity--despite this consultant's efforts to the contrary--was spent in expressed resentment against outside agencies, against the director for admitting unsuitable patients, and at the uncertainty of the future of the hospital's survival or its leadership.

Finally, the one person assigned the duty of coordinating and formulating this diagnostic staff procedure spent some time outside the group, thinking about absolute necessities, and conceived of a plan of altering the procedure which reduced his work and that of other staff members from approximately 12 hours to some 2-1/2 hours per new case. This certainly represented a gain in efficiency, but the quality of this initial assessment, the timeliness of it, and the usefulness of it remained unchanged. Of course, one hopes this man changed his procedure partly as a result of our paying attention again and again to this admitted area of difficulty.

In April and May of 1973 there was almost no creative thinking toward current problems or designing a better future. The stress of the director's uncertain retirement was simply too large an uncertainty for this group to work around. Both his leaving and his staying seemed to pose certain fears for members of the group, and the fears effectively immobilized their planning abilities. Finally, the day of mandatory retirement of the director appeared and a short memo was issued by him announcing his retirement. The very next day the hospital superintendent named a replacement. The new director, a man with more than a decade of service in the state hospital system and with a background in psychology, moved in vigorously and actively to the position of program director.

During the remainder of May and the early portion of June there was considerable hustle and bustle, movement of persons into the area, visits from other persons from the larger part of the hospital, visits that many of the previous staff members felt heralded the new man's bringing in a cadre of top staff of his own. He moved rather quickly to set up himself in a larger office, taking over what had been previously used as the Children's Unit conference room. He moved also to relieve some severe personnel shortages and to appoint an active man in charge of nursing. He was willing, as his time allowed, to meet with me as well as the group of program coordinators that had been meeting more or less regularly, expressing appreciation for our work, encouraging the activities of planning and idea gathering. Nevertheless, the members of the groups seemed to feel uneasy with this new active man, found aspects about his behavior to criticize and to fear, and in general, seemed hesitant to venture forth with clear, decisive recommendations or ideas. In turn, he also was hesitant to set clear new directions, but such hesitation seemed more realistic in that he was gathering information about the unit, its strengths and its needs. Tentative plans were laid to hold a series of conferences with mental health workers from the various counties sending patients to Southside Hospital, but at the end of the consultation period, these plans had not yet been firmed up.

3. An Assessment of the Impact of Intervention

On balance, the consultation intervention seems to have made little impact. Certainly, cohesiveness among the program coordinators was, at the conclusion of the consultation, not yet at a high level, and clear projects have not been described and pursued. The many innovative and successful ideas that are present within the Children's Treatment Unit have not been disseminated thoroughly, and of course, not instituted as regular practice.

Two beneficial outcomes seem distinctly related to the intervention: (1) The school personnel have successfully identified some 88 problems facing them, moved to take action on four or five of the more critical ones, and there is considerably more openness, boldness at making suggestions, considering alternatives; (2) there is among the second level personnel a clear appreciation for the larger view of the network of service of the Children's Unit, a recognition of some of the widespread problems, and a growing awareness that these problems can be tackled, modified, improved. And yet, even though all members seemed to grasp my persistent optimism that matters could be made better, this mode of thought has not become at all widespread, nor do the members clearly see which problems can be tackled by the problem-solving, participative group approach.

A subsequent, independent evaluation may reveal gains that have not been perceived by me. (An interim kind of summary of the consultant's perception of the situation at the Children's Unit is provided in the consultant's Activity Report following his October 31, 1972, visit, and may be found in the appendix to this portion of the report.)

C. What the Independent Evaluator Reported, Based Upon His Interviews at the Children's Treatment Unit in November, 1973, Three Months after Completion of the Consulting Intervention

(This report was submitted by Roland Wilhelmy, PhD, the independent evaluator).

1. Assignment

To meet with certain staff members of the Children's Treatment Unit and to assess and report on the changes that had taken place there since August, 1972. The prime focus of my investigation was the impact that HIRI's consultant's actions had had, but I was also interested in all significant changes regardless of how they came about.

2. Procedure

My visit to the Children's Treatment Unit covered part of 2 days. I conducted a series of interviews with members of the agency staff. These included the director, the head of nursing services, one program coordinator, two speech therapists, the acting principal of the school, two teachers, one charge nurse in the new unit and one social worker. The interviews lasted 1 - 1-1/2 hours each and were conducted in the individual's or group's place of work. Each interview began with three open-ended questions asking the respondent to help the interviewer list the significant events or changes, describe what led up to them and what they in turn, might have led to. Four subsequent questions asked the respondent to state which change seemed most important, to rate the current situation and the situation in August, 1972, on a 100-point scale, to evaluate the institution's readiness and willingness to employ another organizational consultant, and to describe ways in which the client-consultant interaction might have been strengthened. In addition to the questions just described, I had a checklist of items which, on an a priori basis, seemed important to investigate. Both the questions and the checklist are included here.

3. The Interviews

a. The First Three Questions

(These questions are listed in Chapter II, Overview of the Consultation Intervention.)

b. Major Events to Which I Hoped to Evoke Staff Response

In my questioning I was interested in whether any of the staff who had been present during the consultation period could describe and respond to seven events associated with the consultation. These events were:

(1) A series of meetings designed to identify and solve problems related to the school and speech departments.

(2) A series of meetings and related efforts designed to resolve the problem of an ineffective teacher, either by supporting that teacher and emphasizing his strengths or, if that failed, by trying to transfer him out of the Children's Unit.

(3) An effort to raise travel funds for speech department personnel, for visits to other institutions to learn about innovative procedures.

(4) Implementation of goal-setting procedures as described by the outside consultant on goal setting, or developed in various meetings with the HIRI consultant.

(5) An exercise in problem solving involving revision and renovation of the conference room in which the meetings took place.

(6) Review and revision of intake procedures.

(7) Discussion of whether or not the consultant was viewed as a facilitator of relations between the new director and the staff.

Of these events, the only ones recognized by the staff I interviewed were numbers two, four, and six.

c. Some Results of the Interviews

The most significant change at Southside between August, 1972, and August, 1973, was the retirement (in May, 1973) of the director and the appointment of a new director. All other changes are dependent upon this fundamental change. The consultant's intervention appears to have facilitated the changes in the instances to be described, but the actual changes were brought about by the new director. The former director retired after the consultant had spent 11 months of his 1-year consulting period at the institution. Although the consultant did meet with the new director two or three times, no true consulting relationship was established between them because of the limitations of time (the consultant was at Southside only about 3 weeks after the new director was appointed).

The changes reported by the persons I interviewed fall into six categories.

d. Person A's Actions to Strengthen Each of the Children's Units

(1) Changes in nursing staff assignments. In the Children's Unit as a whole there are 131.5 nursing positions. However, over a period of time 21 of these positions had been used to meet emergency and other needs. Four of the nursing positions were used for school personnel, four for staffing in satellite homes, five for janitors and eight for hospital workers. Thus, although there were in theory, an adequate number of nursing positions for the Children's Unit, the unit was in fact, understaffed with nurses.

The new director reconverted some of the positions back to nursing. In addition he closed one of the residential units, and made it into a day care unit for intensive treatment and in-service training. The new unit is staffed with two PhDs and three graduate students plus nursing staff. Its purpose is not only care during the day but also training of nurses from other units in behavior modification and other techniques. Thus, a child with particularly acute problems would spend perhaps 2 or 3 months at the intensive treatment unit during the day along with a nurse from his unit so that both child and nurse would be learning at the same time. The closing of the residential unit involved the transfer of some 18 children into other units, but it strengthened the staffs of the other units simultaneously.

(2) Organizing the professional staff. An ad hoc committee of the program coordinators, professional staff and nursing coordinators meets for regular weekly seminars and also visits other facilities. They have access to a social worker and a PhD consultant. This ad hoc committee generally acts as a consultative and deliberative body, assisting the director in identifying and solving problems. Program coordinators are responsible for the development of the unit program goals. They serve on the ad hoc committee and even though there is no civil service title such as program coordinators, the director has delegated responsibility and authority to them, to carry out their tasks. Program coordinators also participate in the evaluation of the staff. The ad hoc committee is busy developing coeducational activities and converting all the units to coed units. Two of the units currently are coed.

There are now weekend programs for children. Most of these are conducted by the rehab staff. Through the maintenance department, the committee instituted work training contracts which permit children to work for pay. Also contemplated is a car wash designed to help children earn money for themselves. The ad hoc committee is designed to be a committee of "doers"; entrenched personnel unwilling to change and develop are being left out.

One of the persons interviewed felt that the HIRI consultant's original group was limited because it resisted being broadened to include all effective change agents. There was discussion within the group but nothing moved, perhaps because not enough unit coordinators were involved. Still, the consultant had taught a number of problem-solving techniques in the process of getting people to talk to each other for the first time, and this was helpful.

Another person who attended only two or three of the consultant's sessions felt that they didn't add anything and that an outsider so seldom there couldn't penetrate the internal structure. Such penetration would have required visits two or three times per week. He also felt that the consultant became involved in laborious explanation that was unnecessary.

One interviewee felt that the consultant did germinate a feeling of camaraderie. He opened up communication among diverse members of the staff. People had been unwilling to examine the dynamics of the system and to consider changing it. The meetings held with the consultant began a process that made such things possible. The same person also felt that the consultant might have missed some talent by not including more people and that many of the staff didn't know the consultant was doing anything at all. This person reported a reduction of the hostility currently, as compared to the rest of the state hospital. The charge nurses and program coordinators are not involved with training of psychiatric technicians and nursing treatment specialists.

(3) Changes in the school. The principal of the school took a 3-month leave starting in September,1973. During this time, extensive changes were made in the school schedule and in the organization and relation of teachers to the rest of the Children's Unit. The people I talked to about this were unanimous in viewing the changes as constructive but were uncertain about the school principal's possible response.

The official school day was shortened by half an hour and the last class was finished an hour earlier to permit a long period of time in the afternoon in which children, teachers and therapists all could participate in various active physical education activities. The only exceptions to this were teachers and children working on a one-to-one basis on particular problems during this time. During the time the consultant was there, the teachers had been working to shorten the school day in rather the same way as eventually worked out. However, last spring when they first proposed this, the teachers were unable to make a strong case or to justify it well enough. A modified version of their proposal was introduced this fall after the school principal went on leave. The consultant's stimulation of the group in getting them to put this problem and idea for dealing with it on the table, so to speak, may have provided the readiness for action which took place in the fall of 1973.

e. Getting the Units Together

Under the previous directorship the units had been isolated and autonomous. They reported directly to the director and did not communicate with each other to any significant degree. Three major events under this heading include: (1) changes in the school schedule which increased the contact of staff, teachers and children in various therapeutic play; (2) training activities each afternoon; (3) establishment of a more even-handed administration which gave equal attention and support and more individual responsibility to each unit, but permitted less isolation.

Getting the units together involved getting the staff together. Communication was increased among the staff of the Children's Unit, between Children's Unit staff and the rest of Southside State Hospital, and between Children's Unit staff and the outside world in general.

The consultant's greatest contribution grew out of the meetings he conducted with some of the professional staff. Among other things, the meetings dealt with ways to identify and solve problems at the institution. Thus, at least some representatives of the units were somewhat accustomed to communicating with each other and attempting to make plans for the future which involved the entire Children's Unit and not just their own particular responsibilities. Although the meetings showed no tangible results at the time, they were important precursors to the changes which came to fruition only after the consultant had left and the new director had taken over.

In addition, the director's ad hoc committee is an expansion of the consultant's meeting group, in a manner consonant with the new director's style of administration. With the arrival of the new director, the cognitive changes created in the committee were transformed into measurable behavioral changes.

f. Changes in Intake Screening and Admission Procedures

The matters of intake screening and admission procedures were among the subjects identified and reviewed in the group problem-solving meetings with the consultant. Admission procedures have undergone very drastic changes. Formerly, it took approximately 4 months of intake processing before a child could enter the unit. Presently, the Children's Unit as a whole has as its goal the rapid admission of all appropriate children and the director has the ultimate authority to approve or not. Different subunits of the Children's Unit are permitted some intake screening so that the child is placed in the unit most appropriate for him.

Previously, no emergency situations were permitted. Now the Children's Unit will admit a child on the same day he applies, when such emergency procedures are warranted. The Children's Unit sees itself as a last resort for certain kinds of children. Therefore, it endeavors to provide the services for these children as rapidly as possible.

The comments about discharge procedures were less unanimously favorable. Some teachers and speech therapists commented that the alternate care and services unit (ACSU) had usurped on-the-spot judgment in determining when a child was ready for placement outside the hospital and where he should be placed. Thus, someone who knew little about the child was making important decisions; this had not been the case before. On the positive side, a number of satellite homes were being set up in which there is a special training for house parents; there is increased emphasis on development of resources and foster care for children who need it.

g. Goal Planning, Goal Selection

This includes the outside consultant's goal-planning seminar (arranged for by HIRI), and management-by-objectives as a replacement for management-by-crisis.

Only one person I talked to was able to recall the seminar on goal planning at Southside. This person reported that approximately 20 people attended. He thought the seminar was "great--a beautiful job," but that there was a thud at the end of the presentation. The question seemed to be, "Now what?" because the seminar had been given, as it were, in a vacuum. Since then, as mandated by changes in the state regulation, among other things, there have been considerable changes in the documentation of goal planning.

Treatment plans were set up 6 months ago. They are revised regularly. The staff is expected to operate in terms of the treatment plan. However, one person reported that plans are "all on paper," and that, as yet, the staff is not sufficiently familiar with the new documentation to make effective use of it. Goal planning does work better in some units than in others, of course. Those units with more emphasis on behavior modification also tend to be more familiar with goal planning, since behavior modification without planned goals is almost a contradiction in terms. Perhaps as in-service training of the staff continues to develop, goal planning and management-by-objectives may become true operating procedures.

h. Some Conflicting Presumptions among Various Staff Members at the Children's Treatment Unit, Southside State Hospital, about the New Director and the Changes Implemented by Him

A negative pole of the perceptions sees the director as impulsive and someone who imposes his will upon the hospital. A positive pole of the perceptions characterizes the director's actions as a challenge to excellence. That is, the staff is now challenged to be something more than just adequate or competent, as competence had been defined before.

One of the things that the HIRI consultant had commented about was the tendency of the staff to perceive the new director as one who came from the same mold as the former director. This tendency seemed to be autistic in the sense that the perception was not based upon experience or fact. Instead, it seemed to reflect a tendency to interpret every action of the new director as if it had been made by the old director with the old director's intent. Conflicting factual evidence sometimes tended to be denied and then the evidence which could be construed as supporting an autistic hypothesis of authoritarian control was in fact interpreted this way by some.

These response tendencies can be interpreted another way as well. According to the theory of cognitive dissonance, attitudes, beliefs and perceptions tend to become adjusted in ways which justify the perceiver's own actions. If dissonance principles were applied to the situation at Southside State Hospital, it would be predicted that those staff members who resisted the changes interjected by the director would tend to justify themselves by interpreting his actions as arbitrary and impulsive, and as generally detrimental to the children's welfare; those staff members who had cooperated in furthering the changes instituted by the director would tend to see those changes as being maximally constructive, perhaps even as a challenge to excellence.

Another hypothesis could be that the different subgroups of the staff had been treated differently in the first stages of the new director's reorganization of the unit. The nursing staff had previously been subject to repeated deprivation and many of the steps taken by the new director were designed to strengthen the nursing staff and its morale. Some of these changes were made at the expense of teaching staff and other categories. Thus, the nursing staff might be expected to see the changes in a more favorable light than would certain teachers and speech therapists.

On the other hand, the new procedures instituted with respect to the school day and the appointment of a new acting principal would appear to have benefited many of the teachers and to have improved their morale. From this point of view, diverse perceptions of the director may be partially justified as arising out of the same set of actions but coming from different subgroups of staff, depending upon the effect the changes had upon their own areas of responsibility.

One person commented that the former director had been bright but egotistical. He had picked a non-threatening staff who maintained the ship for him. The two prime requirements for the staff had been an interest in children and a form of hero worship of the former director.

The same person pointed out that the new director was less formal and less egotistical but required that the staff work with him. The new director's goals for employees were a well trained staff, open to new methods. It was pointed out that perhaps he had not been on the job long enough to have defined his own image too well. This may have made it easier for some to misread his actions as authoritarian indecisiveness. At any rate, the same person pointed out that certain old-timers felt threatened by the new director and his new procedures. One person expressed the hope that the new director would keep the consultants and researchers under control and restrain them from exploiting the children.

i. Additional Questions

In addition to the three basic questions (recall of all changes at the Children's Treatment Unit since August,1972, how they came about, and what were the results) which formed the core of the interviews, I directed the following four questions to the interviewees.

(1) Which of those changes (discussed above) do you think was the most important or the most useful?

One person felt that the most drastic change was the change in the admissions procedure. Several people thought that the change in directors was the most important. Others said that the establishment of the new day treatment center or the change to a more equitable and even-handed approach in administration would be most important. One person commented that the least constructive thing that HIRI's consultant did was to engage in laborious, detailed explanations during the meetings. Another felt that the change to an emphasis on behavior modification was very important and was associated with considerable improvement in treatment from the custodial care situation that had previously prevailed.

(2) On a scale on which 100 means an absolutely perfect situation and zero means a disastrous failure, would you tell me how you would rate the general situation here now? After the person had responded, the question would continue: Using the same criteria would you rate it as of August, 1972, or the date the person first started to work, if it were a later date?

In asking this question, I explained that a score of 100 would mean the realization of the situation's ideal potential, and a score of zero would mean something worse than merely closing down the institution.

Now	Then
83	40
75	10
62	50
60	55
60	58
60	68
80	74
67	50
(Mean = 70.2)	(Mean = 53.0)
N = 9	N = 9

(3) This was aimed at finding out about the institution's readiness and willingness to employ another organizational consultant. It was phrased in different ways to different individuals.

Southside Children's Unit is accustomed to using various kinds of consultants on a regular basis. Some staff members are accustomed to avoiding the utilization of consultants who appear at the children's unit regularly and there is considerable distrust of an outsider coming into the situation. There are so many constraints operating on the staff from so many different directions that to be effective, the consultant must be either someone who is going to spend an inordinate amount of time understanding all of the ramifications of each action or someone who is already so familiar to the staff that he is not considered an outsider.

The nursing staff seemed to be ready for some kind of organizational consultant and some of the administrative staff seemed to be in the position of being able to make use of organizational consultation.

One person pointed out that the new director is so new that he is a sort of combination insider and consultant. Perhaps he embodies the dream of the consultant in terms of the power to carry out all the plans he would see as useful. One person pointed out that the new director did not make special use of HIRI's consultant nor was HIRI's consultant able to establish a strong relationship with the new director. (There was no time to do so; they overlapped only about three weeks.)

There are various program review units that serve some consulting purposes within the institution. Nursing staff is ready for assistance with changes and in negotiating their administrative roles--and perhaps in management-by-objectives.

Southside Children's Unit seemed to be similar to Valleyview Boys Center, in that both institutions had recently obtained new directors by the time I arrived to conduct these interviews; both were in a period of considerable organizational and procedural change, and both seemed to be in the position of being unable to make effective use of outside organizational consultation. Or--the consultant was not able to bring about basic change in the deep-seated problems that existed and permeated the staff attitudes and behaviors.

(4) Can you tell me some things that the consultant might have done here or done differently? Can you tell me some things that the Children's Unit should have done differently with the consultant? What is the best thing that the Children's Unit and the consultant accomplished?

It was unanimously agreed that what the Children's Unit and the consultant accomplished was to start people talking to each other and establish a certain feeling of camaraderie in the group with which he met regularly for several months. This consultant's group, however, seemed to resist being broadened, as it resisted including other members who they felt were less amenable to change. No unit coordinators were involved and, therefore, thought was not translated into action.

One person wished that the consultant had been more directive and had set down rules instead of wasting time. She wished that the committee had been more task-oriented. She also pointed out that the consultant received no cooperation from the former director, who never set foot in the meeting room. Thus the group always dealt with hypothetical solutions to real problems. The consultant was someone whom the professionals respected and this accounted for the amount of progress in communication and cooperation which was established.

Another person attended only two or three sessions of the group meetings and felt that they didn't add anything, and could not, because an outsider who visited the unit so seldom would be unable to penetrate the internal structure of the institution. The consultant, according to this person, would have been forced to hold meetings two or three times a week in order to be really effective.

Several people expressed the feeling that the consultant hadn't accomplished very much because nothing much could have been accomplished. Another person pointed out that a number of people in the institution didn't know what the consultant was doing and therefore he missed utilizing a lot of existing talent.

4. Report of Issues of A.Priori Interest

In addition to the above seven questions, I had a checklist of questions to which I wished to discover answers myself. These items are phrased in terms of questions I would like to be able to answer, and I tried to make sure, by making very indirect inquiries, that I was able to answer them to my satisfaction.

Do unit supervisors meet together about anything? Do they see themselves as being interrelated with a common task, common problems and common solutions? Unit supervisors or unit coordinators do meet together in the ad hoc committee; they do see themselves as being more interrelated and not as competitive as before. There is less of the squeaky wheel approach that I pointed out previously. Thus, there is some change here; before the consultation, the Children's Unit had been described as nine separate units in isolation from each other.

HIRI's consultant may have helped germinate the degree of cooperation and perception of interrelations that presently exists. The fact that the unit coordinators now *meet* is dependent upon the new director, but the fact that they meet and manage to accomplish something may be due in part to the impact of the consultation.

What perceptions did the teachers have of the school principal? Teachers did not think that the school principal had changed at all. He'd been on leave for the last 3 months and changes had taken place in the school administration, but none of this is likely to be identified with the consultant.

Did the change in the school day duration work out well? Had this produced any increase in communication and cooperation between the unit and the school? The school day duration change has been working successfully and has helped to increase the unit/school communication and cooperation. However, relatively few people see these changes as having stemmed from the efforts of the consultant. The original efforts of the consultant and his group came to no visible fruition, in part because of resistance from the school principal. However, a revised version of the proposal that the group had created was implemented in the fall of 1973 and does seem to be working out well. To the extent that the ideas seemed to germinate and develop, in part, under the consultant's assistance, the consultant should be considered a change agent in helping to facilitate a new school day and in increasing communication between the school and the units.

Is the staff using the rest of the hospital facilities more, e.g., the closed circuit TV, repair services, cable channels, and professional contacts? There is more communication between the Children's Unit and the rest of the hospital now, particularly with the adolescent unit. Most of the facilities of the rest of the hospital are already utilized heavily at the moment, but staff members of the Children's Unit do spend time in other portions of the hospital system for in-service training and other kinds of assistance.

There is a hospital-wide teachers' organization. In the previous administration, people were actively discouraged from seeking assistance anywhere else in the state hospital. Now they are actively encouraged to seek and develop greater communication and cooperation with other parts of the hospital, and with groups outside the hospital. None of this took place prior to the arrival of the new director or the departure of the consultant. It is possible that the staff might have been more ready to utilize the other facilities and to reach out to groups outside the hospital as well because of the consultant's effort, but this is not readily demonstrable.

Is there increased communication by second level people with the outside? Yes, but again, demonstrations of the connection between the consultant's efforts and the present results are difficult to establish.

Did the satellite home plan progress as a greater part of the Children's Unit? The satellite home plan was developed by the former director. It continues to exist and develop. The children's home unit has applied for a federal training and research grant to enable them to train couples as therapists for satellite homes and surrogate parents for difficult children. In addition, the research grant proposed that parents be brought to the Children's Unit for a week at the end of the child's stay. The parents would live in the satellite home and get intensive training in how to care appropriately for their children. Additionally, there would be follow-up services for parents at home. Thus, the satellite home plan has progressed and proposals for its continuation are an integrated part of the Children's Unit. There is no information, however, that HIRI's consultant has had anything to do with its continued development.

What is the level of staff morale? The level of turnover? Are there hopes for the future? Morale is higher for the most part. Turnover went up with the arrival of the new director but is now down. There are hopes for the future and a feeling that no one is locked into any particular procedure or situation any more.

Was there a treatment program set up with a goal plan for each child? Who participated in the setting of such goal plans? As I pointed out earlier, the treatment plans and goal setting may appear more on paper than in reality, but considerable progress has been and continues to be made in in-service training to help the staff utilize goal setting more efficiently and effectively.

Is there some boldness at making suggestions and considering alternatives? People I talked to seemed more willing to talk than I had expected from the reports I'd read. To that degree there was an increase in boldness at making suggestions and considering alternatives. Even the people who were less than contented with the present situation and the changes contemplated were willing to express their discontent to me with little hesitation.

On the other hand, constructive suggestions from the discontented people were rare. The last 6 to 8 months in Southside Children's Unit have involved so much change that it's unlikely many people are sitting around waiting for some change which would get them out of their rut.

Is there increased emphasis on results? Yes, as contrasted to an emphasis on organizational survival, or maintenance, or custodial care of the children, I found considerable emphasis on results. Some of the objections to the changes that had been instituted and contemplated were objections to the increased emphasis on results in the form of behavior modification, as opposed to more cognitive kinds of therapies. It was difficult for me, in a short visit, to distinguish between those who might be resisting change simply to resist any kind of change, and those who had fundamental objections to what they saw as certain immoral or unethical aspects of behavior modification. But prompted by the new director and by changes in state regulation, there is emphasis on measurable results. Again, though, there is no evidence that HIRI's consultant played a major part or any part at all in the present state of affairs. I believe many other factors must have operated more strongly.

5. Summary

Southside State Hospital Children's Unit seems to have achieved a number of things the consultant tried to help it achieve. Most of these changes and achievements are associated with programs instituted by the new director. Often the procedures the director used were not those which would have been recommended by the consultant because of certain ideological differences between the two. However, the end results do seem extraordinarily consistent with the goals the consultant had.

For the most part, regarding the checklist of questions herein, I can report that considerable progress is in evidence. I can also report that it's quite obvious progress would not have taken place without a change in directorship, even though the consultant did succeed in opening the program to talk about goals. Now, certain divisions of the Children's Unit seem to be in a position to take considerable advantage of our organizational consulting services, such as HIRI tried to provide. The problem in separating out and discussing the influence of the consultant from that of other influences at Southside is that both the director's efforts and the consultant's efforts were aimed in approximately the same direction, but from independent formulations. The results were consistent with both efforts, but since the director has considerably more power and spent at least six times as much time carrying out his plans as did the consultant, and since the consultant left almost six months ago, the probabilities of clearly establishing that a particular event is associated principally with the consultant's efforts are quite slim.

All persons interviewed were asked to rate the general situation at Southside on a scale of 0-100, as of August, 1972, and again at the time of the evaluations. The mean score for the earlier date was 53.0 and for the more recent date, 70.2, a gain of 17.2. These ratings came from a total of nine respondents.

D. What is Suggested by the Before-and-After Questionnaire Responses

Below in tabular computer printout form (Table 4) are the responses of the staff at Southside to the 40 items in the BDF administered in 1972 compared with staff response to those same items on the ISSQ in 1973. At the end of this listing are total scores for the Southside staff on the 1972 BDF compared with the 1973 ISSQ.

The second section of Table 4 (NEW ITEMS) lists the responses of the staff at the Children's Unit to new items on the ISSQ which were not included in the BDF. At the end of this section are the total scores for the institution's staff on the 40 new items exclusive to the ISSQ. In addition, total scores for the staff on all 80 ISSQ items are given.

The table is to be read as follows: For item #1, "Quality of intake procedures..." out of a total number (N=60) of respondents from Southside on the 1973 ISSQ, 20% rated Southside on this item as 2 (Fair); 56.67% gave a rating of 3 (Satisfactory); 21.67% gave a rating of 4 (Good); 1.67% gave a rating of 5 (Excellent). And so for each item.

The 1972 responses to the BDF (N=28) for those questions are listed immediately below the ISSQ responses and are to be read in exactly the same way.

On an overall basis, only 4.21% of the respondents from Southside gave their institution a mean rating of 5 (Excellent) on these 40 ISSQ items, compared with 7.95% for the BDF in 1972--a loss of 3.74. It should be noted that the N for respondents on the ISSQ was 60, compared with an N of 28 on the BDF, so that there were more than twice as many persons on the Children's Unit staff who responded to the questionnaire in 1973 compared with 1972. This was a year during which there was growing uncertainty about the future and fate of state hospitals, with much talk of possible additional closings and therefore much uncertainty about future status and job security.

With regard to specific items, there was a higher score on 16 items in 1973 compared with 1972, and a lower score on 24 items. The amounts of difference usually were very small. It is interesting to note here, however, that on the 80th item, which read, "your opinion of the institution as a place in which to work," the ISSQ score was 3.22, compared with 2.71 on the BDF--a gain of .51, which was a larger than usual difference.

ITEM RESPONSE: FORTY OLD ITEMS AND FORTY NEW ITEMS ON THE

CHILDREN'S UNIT, SOUTHSIDE STATE HOSPITAL (N=60)

(For old items, ISSQ responses are listed first,
and 1972 BDF responses are listed immediately below them)

Response Categories: 1 = Poor; 2 = Fair; 3 = Satisfactory; 4 = Good;

RESPONSE CATEGORIES

		1		2		3		4		5	
ITEM		N	%	N	%	N	%	N	%	N	
1	ISSQ	0	0.0	12	20.00	34	56.67	13	21.67	1	1.
	BDF	1	3.57	4	14.29	11	39.29	9	32.14	3	10.
3	ISSQ	0	0.0	4	6.67	32	53.33	19	31.67	5	8.
	BDF	0	0.0	3	10.71	16	57.14	6	21.43	3	10.
4	ISSQ	0	0.0	4	6.67	31	51.67	21	35.00	4	6.
	BDF	0	0.0	3	10.71	16	57.14	5	17.86	4	14.
5	ISSQ	0	0.0	4	6.67	33	55.00	20	33.33	3	5.
	BDF	0	0.0	5	17.86	15	53.57	5	17.86	3	10.
6	ISSQ	1	1.67	9	15.00	29	48.33	20	33.33	1	1.
	BDF	2	7.14	5	17.86	13	46.43	7	25.00	1	3.
8	ISSQ	1	1.67	8	13.33	24	40.00	25	41.67	2	3.
	BDF	0	0.0	2	7.14	14	50.00	9	32.14	3	10.
13	ISSQ	1	1.67	5	8.33	7	11.67	30	50.00	17	28.
	BDF	0	0.0	1	3.57	5	17.86	13	46.43	9	32.
14	ISSQ	1	1.67	9	15.00	26	43.33	22	36.67	2	3.
	BDF	2	7.14	2	7.14	9	32.14	13	46.43	2	7.
15	ISSQ	2	3.33	11	18.33	25	41.67	20	33.33	2	3.
	BDF	2	7.14	3	10.71	11	39.29	11	39.29	1	3.
16	ISSQ	2	3.33	10	16.67	21	35.00	27	45.00	0	0.
	BDF	2	7.14	3	10.71	10	35.71	11	39.29	2	7.
17	ISSQ	3	5.00	6	10.00	26	43.33	22	36.67	3	5.
	BDF	2	7.14	3	10.71	8	28.57	12	42.86	3	10.
20	ISSQ	2	3.33	12	20.00	19	31.67	25	41.67	2	3.
	BDF	2	7.14	2	7.14	10	35.71	12	42.86	2	7.
22	ISSQ	0	0.0	10	16.67	38	63.33	8	13.33	4	6.
	BDF	2	7.14	4	14.29	12	42.86	9	32.14	1	3.
29	ISSQ	1	1.67	8	13.33	21	35.00	29	48.33	1	1.
	BDF	1	3.57	1	3.57	11	39.29	14	50.00	1	3.
31	ISSQ	9	15.00	24	40.00	18	30.00	9	15.00	0	0.
	BDF	5	17.86	5	17.86	6	21.43	10	35.71	2	7.

ITEM RESPONSE: FORTY OLD ITEMS AND FORTY NEW ITEMS ON THE ISSQ AT CHILDREN'S UNIT, SOUTHSIDE STATE HOSPITAL (N=60)

(For old items, ISSQ responses are listed first,
and 1972 BDF responses are listed immediately below them)

ponse Categories: 1 = Poor; 2 = Fair; 3 = Satisfactory; 4 = Good; 5 = Excellent

RESPONSE CATEGORIES										MEAN RES-PONSE	N
1		2		3		4		5			
N	%	N	%	N	%	N	%	N	%		
0	0.0	12	20.00	34	56.67	13	21.67	1	1.67	3.05	60
1	3.57	4	14.29	11	39.29	9	32.14	3	10.71	3.32	28
0	0.0	4	6.67	32	53.33	19	31.67	5	8.33	3.42	60
0	0.0	3	10.71	16	57.14	6	21.43	3	10.71	3.32	28
0	0.0	4	6.67	31	51.67	21	35.00	4	6.67	3.42	60
0	0.0	3	10.71	16	57.14	5	17.86	4	14.29	3.36	28
0	0.0	4	6.67	33	55.00	20	33.33	3	5.00	3.37	60
0	0.0	5	17.86	15	53.57	5	17.86	3	10.71	3.21	28
1	1.67	9	15.00	29	48.33	20	33.33	1	1.67	3.18	60
2	7.14	5	17.86	13	46.43	7	25.00	1	3.57	3.00	28
1	1.67	8	13.33	24	40.00	25	41.67	2	3.33	3.32	60
0	0.0	2	7.14	14	50.00	9	32.14	3	10.71	3.46	28
1	1.67	5	8.33	7	11.67	30	50.00	17	28.33	3.95	60
0	0.0	1	3.57	5	17.86	13	46.43	9	32.14	4.07	28
1	1.67	9	15.00	26	43.33	22	36.67	2	3.33	3.25	60
2	7.14	2	7.14	9	32.14	13	46.43	2	7.14	3.39	28
2	3.33	11	18.33	25	41.67	20	33.33	2	3.33	3.15	60
2	7.14	3	10.71	11	39.29	11	39.29	1	3.57	3.21	28
2	3.33	10	16.67	21	35.00	27	45.00	0	0.0	3.22	60
2	7.14	3	10.71	10	35.71	11	39.29	2	7.14	3.29	28
3	5.00	6	10.00	26	43.33	22	36.67	3	5.00	3.27	60
2	7.14	3	10.71	8	28.57	12	42.86	3	10.71	3.39	28
2	3.33	12	20.00	19	31.67	25	41.67	2	3.33	3.22	60
2	7.14	2	7.14	10	35.71	12	42.86	2	7.14	3.36	28
0	0.0	10	16.67	38	63.33	8	13.33	4	6.67	3.10	60
2	7.14	4	14.29	12	42.86	9	32.14	1	3.57	3.11	28
1	1.67	8	13.33	21	35.00	29	48.33	1	1.67	3.35	60
1	3.57	1	3.57	11	39.29	14	50.00	1	3.57	3.45	28
9	15.00	24	40.00	18	30.00	9	15.00	0	0.0	2.45	60
5	17.86	5	17.86	6	21.43	10	35.71	2	7.14	2.96	28

Response Categories

		1		2		3		4		5	
Item		N	%	N	%	N	%	N	%	N	
32	ISSQ	1	1.67	8	13.33	26	43.33	21	35.00	4	6
	BDF	0	0.0	5	17.86	7	25.00	11	39.29	5	17
33	ISSQ	9	15.00	21	35.00	18	30.00	9	15.00	3	5
	BDF	2	7.14	7	25.00	13	46.43	4	14.29	2	7
35	ISSQ	6	10.00	8	13.33	33	55.00	12	20.00	1	1
	BDF	3	10.71	9	32.14	12	42.86	4	14.29	0	0
36	ISSQ	12	20.00	23	38.33	19	31.67	4	6.67	2	3
	BDF	9	32.14	11	39.29	4	14.29	3	10.71	1	3
42	ISSQ	2	3.33	9	15.00	31	51.67	17	28.33	1	1
	BDF	2	7.14	8	28.57	13	46.43	5	17.86	0	0
43	ISSQ	19	31.67	28	46.67	6	10.00	6	10.00	1	1
	BDF	11	39.29	12	42.86	2	7.14	3	10.71	0	0
44	ISSQ	0	0.0	1	1.67	15	25.00	41	68.33	3	5
	BDF	0	0.0	3	10.71	11	39.29	11	39.29	3	10
45	ISSQ	10	16.67	11	18.33	23	38.33	15	25.00	1	1
	BDF	2	7.14	7	25.00	10	35.71	8	28.57	1	3
46	ISSQ	7	11.67	10	16.67	27	45.00	14	23.33	2	3
	BDF	5	17.86	6	21.43	8	28.57	8	28.57	1	3
47	ISSQ	6	10.00	8	13.33	26	43.33	17	28.33	3	5
	BDF	4	14.29	5	17.86	9	32.14	5	17.86	5	17
48	ISSQ	8	13.33	19	31.67	21	35.00	10	16.67	2	3
	BDF	4	14.29	9	32.14	3	10.71	8	28.57	4	14
49	ISSQ	10	16.67	20	33.33	18	30.00	10	16.67	2	3
	BDF	7	25.00	8	28.57	8	28.57	4	14.29	1	3
50	ISSQ	9	15.00	17	28.33	26	43.33	6	10.00	2	3
	BDF	6	21.43	7	25.00	9	32.14	4	14.29	2	7
53	ISSQ	0	0.0	16	26.67	25	41.67	19	31.67	0	0
	BDF	2	7.14	8	28.57	6	21.43	12	42.86	0	0
58	ISSQ	11	18.33	33	55.00	11	18.33	5	8.33	0	0
	BDF	6	21.43	17	60.71	2	7.14	3	10.71	0	0

Response Categories 1 N	%	2 N	%	3 N	%	4 N	%	5 N	%	Mean Response	N
1	1.67	8	13.33	26	43.33	21	35.00	4	6.67	3.32	60
0	0.0	5	17.86	7	25.00	11	39.29	5	17.86	3.57	28
9	15.00	21	35.00	18	30.00	9	15.00	3	5.00	2.60	60
2	7.14	7	25.00	13	46.43	4	14.29	2	7.14	2.89	28
6	10.00	8	13.33	33	55.00	12	20.00	1	1.67	2.90	60
3	10.71	9	32.14	12	42.86	4	14.29	0	0.0	2.61	28
12	20.00	23	38.33	19	31.67	4	6.67	2	3.33	2.35	60
9	32.14	11	39.29	4	14.29	3	10.71	1	3.57	2.14	28
2	3.33	9	15.00	31	51.67	17	28.33	1	1.67	3.10	60
2	7.14	8	28.57	13	46.43	5	17.86	0	0.0	2.75	28
19	31.67	28	46.67	6	10.00	6	10.00	1	1.67	2.03	60
11	39.29	12	42.86	2	7.14	3	10.71	0	0.0	1.89	28
0	0.0	1	1.67	15	25.00	41	68.33	3	5.00	3.77	60
0	0.0	3	10.71	11	39.29	11	39.29	3	10.71	3.50	28
10	16.67	11	18.33	23	38.33	15	25.00	1	1.67	2.77	60
2	7.14	7	25.00	10	35.71	8	28.57	1	3.57	2.96	28
7	11.67	10	16.67	27	45.00	14	23.33	2	3.33	2.90	60
5	17.86	6	21.43	8	28.57	8	28.57	1	3.57	2.79	28
6	10.00	8	13.33	26	43.33	17	28.33	3	5.00	3.05	60
4	14.29	5	17.86	9	32.14	5	17.86	5	17.86	3.07	28
8	13.33	19	31.67	21	35.00	10	16.67	2	3.33	2.65	60
4	14.29	9	32.14	3	10.71	8	28.57	4	14.29	2.96	28
10	16.67	20	33.33	18	30.00	10	16.67	2	3.33	2.57	60
7	25.00	8	28.57	8	28.57	4	14.29	1	3.57	2.43	28
9	15.00	17	28.33	26	43.33	6	10.00	2	3.33	2.58	60
6	21.43	7	25.00	9	32.14	4	14.29	2	7.14	2.61	28
0	0.0	16	26.67	25	41.67	19	31.67	0	0.0	3.05	60
2	7.14	8	28.57	6	21.43	12	42.86	0	0.0	3.00	28
11	18.33	33	55.00	11	18.33	5	8.33	0	0.0	2.17	60
6	21.43	17	60.71	2	7.14	3	10.71	0	0.0	2.07	28

Item		Response Categories									
		1		2		3		4		5	
		N	%	N	%	N	%	N	%	N	
59	ISSQ	8	13.33	8	13.33	33	55.00	9	15.00	2	3
	BDF	6	21.43	13	46.43	6	21.43	3	10.71	0	0
60	ISSQ	7	11.67	11	18.33	15	25.00	18	30.00	9	15
	BDF	4	14.29	2	7.14	4	14.29	8	28.57	10	35
61	ISSQ	2	3.33	8	13.33	25	41.67	18	30.00	7	11
	BDF	2	7.14	2	7.14	7	25.00	12	42.86	5	17
62	ISSQ	0	0.0	14	23.33	31	51.67	14	23.33	1	1
	BDF	3	10.71	2	7.14	7	25.00	12	42.86	4	14
66	ISSQ	6	10.00	17	28.33	27	45.00	9	15.00	1	1
	BDF	3	10.71	14	50.00	8	28.57	3	10.71	0	0
67	ISSQ	4	6.67	28	46.67	18	30.00	9	15.00	1	1
	BDF	4	14.29	5	17.86	12	42.86	7	25.00	0	0
68	ISSQ	7	11.67	15	25.00	33	55.00	4	6.67	1	1
	BDF	4	14.29	3	10.71	14	50.00	6	21.43	1	3
70	ISSQ	6	10.00	15	25.00	23	38.33	14	23.33	2	3
	BDF	3	10.71	7	25.00	9	32.14	8	28.57	1	3
76	ISSQ	1	1.67	9	15.00	38	63.33	12	20.00	0	0
	BDF	0	0.0	2	7.14	8	28.57	15	53.57	3	10
80	ISSQ	2	3.33	6	10.00	32	53.33	17	28.33	3	5
	BDF	3	10.71	8	28.57	11	39.29	6	21.43	0	0
TOTAL	ISSQ	176	7.33	499	20.79	984	41.00	640	26.67	101	4
	BDF	116	10.36	226	20.18	370	33.04	319	28.48	89	7

NEW ITEMS

ITEM		RESPONSE CATEGORIES									
		1		2		3		4		5	
		N	%	N	%	N	%	N	%	N	
2	ISSQ	7	11.67	15	25.00	28	46.67	7	11.67	3	5
7	ISSQ	3	5.00	15	25.00	30	50.00	12	20.00	0	0
9	ISSQ	12	20.00	28	46.67	13	21.67	6	10.00	1	1
10	ISSQ	1	1.67	10	16.67	36	60.00	12	20.00	1	1
11	ISSQ	0	0.00	4	6.67	18	30.[illegible]	36	60.00	2	3
12	ISSQ	0	0.00	5	8.33	13	21.67	34	56.67	8	13
18	ISSQ	0	0.00	5	8.33	20	33.33	34	56.67	1	1
19	ISSQ	1	1.67	7	11.67	31	51.67	18	30.00	3	5
21	ISSQ	1	1.67	5	8.33	34	56.67	19	31.67	1	1
23	ISSQ	0	0.00	14	23.33	36	60.00	10	16.67	0	0
24	ISSQ	0	0.00	14	23.33	24	40.00	20	33.33	2	3

Response Categories										Mean Response	N
1		2		3		4		5			
N	%	N	%	N	%	N	%	N	%		
8	13.33	8	13.33	33	55.00	9	15.00	2	3.33	2.82	60
6	21.43	13	46.43	6	21.43	3	10.71	0	0.0	2.21	28
7	11.67	11	18.33	15	25.00	18	30.00	9	15.00	3.18	60
4	14.29	2	7.14	4	14.29	8	28.57	10	35.71	3.64	28
2	3.33	8	13.33	25	41.67	18	30.00	7	11.67	3.33	60
2	7.14	2	7.14	7	25.00	12	42.86	5	17.86	3.57	28
0	0.0	14	23.33	31	51.67	14	23.33	1	1.67	3.03	60
3	10.71	2	7.14	7	25.00	12	42.86	4	14.29	3.43	28
6	10.00	17	28.33	27	45.00	9	15.00	1	1.67	2.70	60
3	10.71	14	50.00	8	28.57	3	10.71	0	0.0	2.32	28
4	6.67	28	46.67	18	30.00	9	15.00	1	1.67	2.58	60
4	14.29	5	17.86	12	42.86	7	25.00	0	0.0	2.79	28
7	11.67	15	25.00	33	55.00	4	6.67	1	1.67	2.62	60
4	14.29	3	10.71	14	50.00	6	21.43	1	3.57	2.89	28
6	10.00	15	25.00	23	38.33	14	23.33	2	3.33	2.85	60
3	10.71	7	25.00	9	32.14	8	28.57	1	3.57	2.89	28
1	1.67	9	15.00	38	63.33	12	20.00	0	0.0	3.02	60
0	0.0	2	7.14	8	28.57	15	53.57	3	10.71	3.68	28
2	3.33	6	10.00	32	53.33	17	28.33	3	5.00	3.22	60
3	10.71	8	28.57	11	39.29	6	21.43	0	0.0	2.71	28
176	7.33	499	20.79	984	41.00	640	26.67	101	4.21	3.00	
116	10.36	226	20.18	370	33.04	319	28.48	89	7.95	3.03	

NEW ITEMS

RESPONSE CATEGORIES										MEAN RES-PONSE	N
1		2		3		4		5			
N	%	N	%	N	%	N	%	N	%		
7	11.67	15	25.00	28	46.67	7	11.67	3	5.00	2.73	60
3	5.00	15	25.00	30	50.00	12	20.00	0	0.00	2.85	60
12	20.00	28	46.67	13	21.67	6	10.00	1	1.67	2.27	60
1	1.67	10	16.67	36	60.00	12	20.00	1	1.67	3.03	60
0	0.00	4	6.67	18	30.00	36	60.00	2	3.33	3.60	60
0	0.00	5	8.33	13	21.67	34	56.67	8	13.33	3.75	60
0	0.00	5	8.33	20	33.33	34	56.67	1	1.67	3.52	60
1	1.67	7	11.67	31	51.67	18	30.00	3	5.00	3.25	60
1	1.67	5	8.33	34	56.67	19	31.67	1	1.67	3.23	60
0	0.00	14	23.33	36	60.00	10	16.67	0	0.00	2.93	60
0	0.00	14	23.33	24	40.00	20	33.33	2	3.33	3.17	60

		Response Categories									
		1		2		3		4		5	
Item		N	%	N	%	N	%	N	%	N	
25	ISSQ	3	5.00	12	20.00	21	38.33	19	31.67	3	5.
26	ISSQ	1	1.67	10	16.67	22	36.67	26	43.33	1	1.
27	ISSQ	3	5.00	13	21.67	31	51.67	12	20.00	1	1.
28	ISSQ	1	1.67	5	8.33	16	26.67	31	51.67	7	11.
30	ISSQ	10	16.67	17	28.33	22	36.67	9	15.00	2	3.
34	ISSQ	3	5.00	20	33.33	25	41.67	10	16.67	2	3.
37	ISSQ	6	10.00	16	26.67	32	53.33	6	10.00	0	0.
38	ISSQ	1	1.67	8	13.33	23	38.33	27	45.00	1	1.
39	ISSQ	0	0.00	8	13.33	28	46.67	24	40.00	0	0.
40	ISSQ	4	6.67	16	26.67	24	40.00	16	26.67	0	0.
41	ISSQ	2	3.33	16	26.67	23	38.33	18	30.00	1	1.
51	ISSQ	11	18.33	7	11.67	34	56.67	8	13.33	0	0.
52	ISSQ	1	1.67	13	21.67	20	33.33	22	36.67	4	6.
54	ISSQ	1	1.67	23	38.33	18	30.00	17	28.33	1	1.
55	ISSQ	5	8.33	16	26.67	34	56.67	4	6.67	1	1.
56	ISSQ	7	11.67	30	50.00	18	30.00	5	8.33	0	0.
57	ISSQ	2	3.33	11	18.33	40	66.67	5	8.33	2	3.
63	ISSQ	3	5.00	18	30.00	26	43.33	13	21.67	0	0.
64	ISSQ	1	1.67	23	38.33	27	45.00	9	15.00	0	0.
65	ISSQ	7	11.67	18	30.00	25	41.67	10	16.67	0	0.
69	ISSQ	7	11.67	9	15.00	33	55.00	10	16.67	1	1.
71	ISSQ	2	3.33	19	31.67	21	35.00	17	28.33	1	1.
72	ISSQ	3	5.00	8	13.33	43	71.67	6	10.00	0	0.
73	ISSQ	3	5.00	10	16.67	34	56.67	10	16.67	3	5.
74	ISSQ	4	6.67	11	18.33	28	46.67	15	25.00	2	3.
75	ISSQ	5	8.33	24	40.00	22	36.67	6	10.00	3	5.
77	ISSQ	1	1.67	12	20.00	34	56.67	11	18.33	2	3.
78	ISSQ	3	5.00	22	36.67	29	48.33	6	10.00	0	0.
79	ISSQ	7	11.67	20	33.33	24	40.00	9	15.00	0	0.
TOTAL	NEW	132	5.50	557	23.21	1062	44.25	589	24.54	60	2.
	ALL	308	6.42	1056	22.00	2046	42.62	1229	25.60	161	3.

Response Categories										Mean	
1		2		3		4		5		Res-	N
N	%	N	%	N	%	N	%	N	%	ponse	
3	5.00	12	20.00	23	38.33	19	31.67	3	5.00	3.12	60
1	1.67	10	16.67	22	36.67	26	43.33	1	1.67	3.27	60
3	5.00	13	21.67	31	51.67	12	20.00	1	1.67	2.92	60
1	1.67	5	8.33	16	26.67	31	51.67	7	11.67	3.63	60
10	16.67	17	28.33	22	36.67	9	15.00	2	3.33	2.60	60
3	5.00	20	33.33	25	41.67	10	16.67	2	3.33	2.80	60
6	10.00	16	26.67	32	53.33	6	10.00	0	0.00	2.63	60
1	1.67	8	13.33	23	38.33	27	45.00	1	1.67	3.32	60
0	0.00	8	13.33	28	46.67	24	40.00	0	0.00	3.27	60
4	6.67	16	26.67	24	40.00	16	26.67	0	0.00	2.87	60
2	3.33	16	26.67	23	38.33	18	30.00	1	1.67	3.00	60
11	18.33	7	11.67	34	56.67	8	13.33	0	0.00	2.65	60
1	1.67	13	21.67	20	33.33	22	36.67	4	6.67	3.25	60
1	1.67	23	38.33	18	30.00	17	28.33	1	1.67	2.90	60
5	8.33	16	26.67	34	56.67	4	6.67	1	1.67	2.67	60
7	11.67	30	50.00	18	30.00	5	8.33	0	0.00	2.35	60
2	3.33	11	18.33	40	66.67	5	8.33	2	3.33	2.90	60
3	5.00	18	30.00	26	43.33	13	21.67	0	0.00	2.82	60
1	1.67	23	38.33	27	45.00	9	15.00	0	0.00	2.73	60
7	11.67	18	30.00	25	41.67	10	16.67	0	0.00	2.63	60
7	11.67	9	15.00	33	55.00	10	16.67	1	1.67	2.82	60
2	3.33	19	31.67	21	35.00	17	28.33	1	1.67	2.93	60
3	5.00	8	13.33	43	71.67	6	10.00	0	0.00	2.87	60
3	5.00	10	16.67	34	56.67	10	16.67	3	5.00	3.00	60
4	6.67	11	18.33	28	46.67	15	25.00	2	3.33	3.00	60
5	8.33	24	40.00	22	36.67	6	10.00	3	5.00	2.63	60
1	1.67	12	20.00	34	56.67	11	18.33	2	3.33	3.02	60
3	5.00	22	36.67	29	48.33	6	10.00	0	0.00	2.63	60
7	11.67	20	33.33	24	40.00	9	15.00	0	0.00	2.58	60
32	5.50	557	23.21	1062	44.25	589	24.54	60	2.50	2.95	
108	6.42	1056	22.00	2046	42.62	1229	25.60	161	3.35	2.97	

This might be related to feelings about the change in directors and the improvements which were being instituted--a number of which, as noted by the independent evaluator, were identified as needed in the sessions with the consultant, but in several instances not implemented until after the new director arrived.

In terms of overall score comparison, the mean for Southside on the 1972 BDF was 3.08, compared with 3.00 on the 1973 ISSQ--an insignificant difference.

E. Commentary by Edward M. Glaser, PhD, Project Director, on the Consultation Intervention at Southside

While some important modus operandi and communication improvements appear to have been facilitated by the consulting intervention, according to the findings of the independent evaluator, and these have resulted in improved institutional efficiency and effectiveness, it also has been noted that implementation in most cases did not occur until after a new director was appointed, upon retirement of his predecessor at age 70.

A key to this outcome appears to be in the fact that the director, who exercised a great deal of influence and control over the operation of the Children's Treatment Center, was not personally involved in the consultation effort. He gave it his support only in allowing it to proceed. He did not encourage people to come to meetings or convey to them the idea that the meetings were important or valuable for them. Yet his approval, ego-investment and active commitment were perceived by the staff group with whom the consultant worked as necessary to deal effectively with the problems identified and the tentative solutions proposed by others.

Two minimal conditions probably should have been required for the continuation of this consultation effort, which if not achievable should have resulted in withdrawal of the consultation at this institution.

1. If the director did not wish to attend the problem-identification and problem-solving sessions...or if the staff felt freer to discuss problems and opportunities without his presence until they had worked given issues through to a recommended course of action...it was necessary for the director to inform the group unequivocally, in a face-to-face open discussion, regarding his support of the consultation effort and what he hoped might be gained from it for the benefit of all concerned. In effect, the director needed to set goals or at least expectations of constructive outcomes, and needed to let the group know that problem-identification and proposals for resolving the identified problems would be nondefensively welcomed, wanted, and given positive reinforcement.

2. The staff group who attended these meetings with the consultant needed to be more representative of a broader base of functions and power in the Children's Unit (no unit coordinators were present and only one of the two psychologists involved had any authority). Each participant needed to make a personal commitment to invest himself or herself in this opportunity to take stock and try to work out improvements--or not be a member of the group. In effect, given the opportunity, they had concomitant responsibilities if they wished to be a voluntary member of the group which the director was encouraging (given point #1 above).

The consultant did not specify, require or achieve acceptance of these conditions. In effect, he appeared to become infected with the malaise or discouragement of the staff.

The HIRI project director, in turn, was overconcerned with allowing the consultant to work things out in his own style, and thus did not intervene decisively. This happened partly because one of the hypotheses was that a great variety of well-trained consultants probably could help an organization improve its effectiveness and efficiency if the key members of the organization could be brought around to a situation where they felt disposed (and safe) to review their (the organization's) goals, take stock of where they and their programs stood with regard to goal attainment, then pool their collective wisdom about implementing ideas for improvement or renewal, followed by frequent feedback of performance results compared with measured baseline data. In the Southside case, two of the essential conditions for testing this hypothesis were absent. If ways could not be found to overcome these lacks within the first 2-3 months of the consultation effort, HIRI should have withdrawn, and transferred the resources allocated for Southside to another institution.

Activity Report # 9

by

Andrew V. Morrison

Children's Unit, Southside State Hospital October 31, 1972

I. What I Did, with Whom, at Whose Request, Duration, Purpose

Today I met (by my request) with seven members of the middle management staff of the Children's Unit of Southside State Hospital for a 2 1/2 hour block of time. At this meeting I was accompanied by Dave Berger of HIRI.

The chief purpose of this meeting was to insure that I would be working during the next 9 months with a minimum of four of the program coordinators at Children's Unit. Additional purposes included: the sharing of my major observations concerning Children's Unit, correction by their inputs of those observations, informing them that I had some 20 consultation days available for their use, my suggesting some things we could do with that time, and, finally, getting commitment from them that we would be working together.

The meeting was held in the unit office of A, that being a centrally located place and adequately large for all those in attendance. I had by telephone invited eight persons to the meeting, selecting from the Children's Unit those eight persons most likely to grasp what I was trying to say, most likely being able to react candidly and critically and with suggestions of their own. Of the eight persons invited, seven appeared; they were six program coordinators and the school principal.

II. Observations and Impressions on the Day's Significant Events

A. Meeting with the seven persons listed above; actually, 9:45 a.m. to 12:15 p.m.

The meeting mentioned above had been scheduled to begin at 9:30 and terminate at 11:30, but others did not arrive punctually, nor were we able to arrive at agreements by 11:30, so the meeting was extended. After introductions and settling down, I stated the purpose of the meeting was threefold: to inform them of some of my findings, to extend to them information concerning the future, and to invite them to participate in consultation during the coming year.

I mentioned ten major observations that I felt were correct about the Children's Unit. The observations were as follows:

1. There are eight hospitals here at the Children's Unit and a school that relates to all of those hospitals.

2. The programs in each of the "mini-hospitals" differ widely one from the other, partly because they have different patient populations, but also because each program is relatively independent from the other and there seems to be little interaction between the mini-hospitals.

3. The aims and purposes of Children's Unit, as well as the individual mini-hospitals, are not stated clearly by the leaders involved.

4. Because aims and purposes are stated vaguely, no one knows if goals are being met.

5. B is a powerful force within the Children's Unit--or potentially so on each of the individual units.

6. B's retirement in May of 1973 is uncertain, and this seems to leave an aura of uncertainty and anxiety in the staff.

7. There seem to be no cost/effectiveness data available, no data available to determine whether an activity is worth its cost.

8. There is at the Children's Unit no cherished "success mythology" --that is to say, I did not hear anecdotes or stories told about even a single success that the Children's Unit had managed with an individual patient.

9. There seems to be a "log jam" at the release end of the treatment phase.

10. The emphasis by everybody seems to be on making an effort, introducing a certain climate, and the emphasis on these activities obscures the results obtained, even obscures the search for knowledge of results.

After I had read the list of major observations above, I asked for corrections or comments. In general, persons seemed to agree with my observations except as follows: C questioned whether the presence of eight hospitals was a detriment rather than an asset, and we interchanged comments on that, with my emphasizing there seemed to be an inadequate interaction between the "mini-hospitals." Additionally, C questioned whether there was indeed a log jam at the release end of the treatment phase, insofar as there was no "log jam" of applicants at the present time. He seemed to be saying that the way to tell where there was a log jam at the end was to see if there was one at the beginning. I disagreed with that conception, as did a number of other persons at the meeting, many of them stating that patients could not be expediently released, and then their adjustment "goes sour." A questioned whether results are measured, and emphasized that within the school program every child is measured and their results are known. D also challenged this observation a bit, saying that indeed on her tiny unit (6 patients only) they did know what results they were getting. I responded that the results seemed to be within the hospital treatment phase only, and there was little follow-up knowledge as to the consequences and success of the patient after he terminates the hospital phase. In general, persons agreed, stating that often the patient was inappropriately placed to the detriment of their work together with the patient during the hospital phase. On the other hand, D reported one recently released young girl who had made great gains in the hospital and now, 6 months after release, is functioning beautifully in her own neighborhood school setting.

In general, however, the persons attending the meeting agreed with the observations, but felt that the solutions lay in agencies or persons outside themselves. (See Dave Berger's written comments concerning the pessimism extant in this group.)

After stating that I would be available some 20 days between now and July, 1973, I proceeded to itemize a number of things that we could do--should they be willing and interested. These included:

1. Holding problem-finding meetings on each unit so that the program coordinators could learn clearly to separate the locating of problems from the solving of problems.

2. Teach and initiate solution-finding meetings at each unit, the aim being to firmly establish a problem-solving approach of a more effective nature.

3. Institute goal planning for the individual patients as well as establishing clear-cut goals for the individual treatment units.

4. By instituting goal planning, we should be able to establish clearer criteria regarding when a child is ready to leave--and to what sort of setting.

5. Establish more clearly in our own heads four classes of "community" so that when a child has been assessed as ready to leave, that child can be aimed more precisely for a target community suitable for his-her level of adjustment.

6. We might establish improved relationships with, say, six schools to insure that a patient graduating from the Children's Unit would encounter school success.

7. We might make site visits to Devereux Schools at Santa Barbara or other places to gather specific information as to how they function.

After having read these possible activities, I asked for reactions and comments and suggestions. In general there was little enthusiasm for these ideas, considerable statements to the effect that others should solve certain of the problems (relationships with the schools, clarification of types of community placement). Additionally, D felt that problem identification sessions would be an academic endeavor unless B and E attended these meetings to know what the problems were--and possibly--to be confronted with that situation.

I responded to a number of these comments with the sort of statement such as this: Others have not solved these problems--and we might wait another 20 years for them to do so--but what if we looked at the above types of activities as part of our responsibilities? For example, to write up in lucid terms four classes of community placements that are sorely needed, writing it in such a way that anybody could pretty well understand what was needed, and then find or establish the desired sort of setting. Additionally, since many children have not been treated well upon their leaving, what would be the consequence of writing something like an "operator's manual" for an automobile--or a set of instructions--to the next worker on how best to handle the child so that what growth and adjustment has been achieved will both be maintained and furthered? Additionally, I was willing to attempt to at some later time set up a problem identification meeting with B present, but reflected that at the present time this seemed impossible to bring about, premature, but is certainly something to be considered.

With further discussion, F, the School Principal, enthused considerably about problem identification and solving sessions with his school teachers, enthused about the possibility of setting up a liaison with community schools so as to insure a child's subsequent school success. With this encouragement and lead, I asked rather directly whether they wished to make suggestions as to how we could work together or should we begin holding problem identification training sessions, later sessions on their individual units. There was moderate reluctance in accepting the idea, but G, F, A and H indicated their willingness to work with me in the coming year. We arranged to have the 2-hour problem-finding training session on the following Tuesday, that meeting from 9:30 a.m. to 11:30 a.m.

This particular meeting terminated at 12:15 p.m.

B. Attempt to Meet with B

Dave Berger and I went from A's office to the administration building of the Children's Unit, hoping to see B and inform him of what we had done and our subsequent plans, but B was at lunch (he customarily takes a 30-minute lunch period at his own residence on the hospital grounds), and we were unable to see him at that time.

C. Luncheon Conference with Dave Berger Concerning this Morning's Meeting

Dave Berger and I drove in separate cars to a nearby city and had lunch together and discussed the meeting. See his report for his observations. As I recall it, he was impressed with the degree of pessimism and depression that exists among these apparently very bright people, emphasizing that they seemed to be at that state of adjustment in which to some extent they enjoyed their suffering and were doing things that would maintain the situation as is.

III. Interpretation and Analysis

As was Dave Berger, I was impressed with the lethargy, the lassitude of many of the program coordinators. Although I don't quite see it as he does, namely, that their activities are designed (consciously or unconsciously) to maintain the system as is; I was impressed with the amount of "nay-saying" that seemed to be present, the painful explanations that a problem was outside their province, and many, many remarks that seemed to reflect a hesitancy, a withdrawal from the larger scope of things, a reflection of only so-so self-esteem and sense of potency. I had had 3 years staff experience at Southside State Hospital and encountered what these people had been saying at that time among the staff, but then and with that staff the lethargy and inertia seemed even larger, more profound, so to inspire that staff was more of an accomplishment. Hence, as I listen and look at these particular program coordinators I see the same themes but not at quite the depth of resignation as is perhaps even average among the staff members at Southside State Hospital. As I recall my own 3 years of duty there, I recall being sort of indoctrinated by the staff as to the futility of making changes, and this indoctrination was relatively subtle and persistent. Is that still going on? What happens to a bright young graduate student with a fresh PhD or M.D. and he comes to the Children's Unit? How quickly can his initial confidence and aspirations be brought into the institutional standard? Dave Berger's comments certainly aroused memories and created a different framework for looking at the behavior of these program coordinators. I recall, now, that a number of active and energetic and well intentioned young staff hired on at Southside State Hospital, encountered some major discrepancy between what they thought was correct and existing procedures, and left rather rapidly to some other institution or private practice. Those that remained often were absorbed into the "nothing really of importance can be done" philosophy that seemed to permeate the place, but I was fortunate to team up with initially one and then four other persons who worked together for 18 months to build new programs, institute new practices, etc. That team of five persons would meet frequently at work, weekly on off-duty hours, and we concluded that practically any reasonable idea could be implemented at the hospital at that time if it seemed sensible, if the right persons were informed and brought on board, and if the program didn't bring great risks to the reputation of the medical director. With that in mind, we were able and did institute a number of rather large changes.

The staff at the Childrens' Unit does not seem to have welded itself into a self-help team or network, hence suggestions often die aborning, many reasons why something can't be done are proffered, and only modest achievement is forthcoming from this group of well trained, highly intelligent, well paid staff. The fire of life has not by any means died in these people, but it often seems reserved for their individual programs, nurtured in a sort of isolation and withdrawal, and not spent on forming teams, sharing interaction ideas, establishing project goals, making suggestions, following through on them, etc. In this respect, my relationship with them, it seems to me, will be a bit more like that of a psychotherapist to an individual or work group, initially encouraging greater activity, suggesting ideas, fostering self esteem, building relationships between them and me, and only later will we be able to examine nondefensively the personal, unit and entire Children's Unit's goals. To be sure, such goal clarification and the setting of objectives is extremely important, but I have not in my experience been able to work with relatively troubled persons initially on such matters. First, it seems to me, we always must sort of check each other out, establish a relationship of moderate trust, solve some of the pressing problems that upset them, and later move toward more specific goals and even later toward the examination of lifetime goals. I suspect the same procedure will unfold with this group at the Children's Unit, insofar as much of their time is spent in coping with existing problems, coping defensively rather than creatively. Thus, at the moment I see the procedure possibly unfolding with problem identification sessions, problem-solving sessions, learning to set behaviorally stated goals for individual patients, setting behaviorally stated goals for the unit and later for the Children's Unit itself. In terms of a time sequence, possible problem identification will occur in November, problem-solving training and experience in December, an initial run at goal setting in January, etc.

Dave Berger's presence was especially helpful to me for two reasons: First, at one point in the meeting he rather sharply confronted the group by saying, "It is not what we or Andy can do for you, but what do you want to do, what are you going to suggest?" (I've captured the gist of it, but missed the actual words, but the comment got through to the group.) Second, his lunch time comments concerning the pessimism and how the individuals seemed to maintain the system by nourishing their complaints brought a slightly different perspective to my mind, but also helped me focus more clearly that here we have a number of individuals sort of in trouble at their work and that we must work with the individual apathy, fearfulness, nay-saying first. His perception of the degree of difficulty was, as has been mentioned before, somewhat graver than mine, but I have both greater clarity how to proceed and more hope of success as a result of his visit and comments.

IV. Did We Accomplish Today's Stated Objectives?

Yes, but not with quite the degree of clarity, speed and enthusiasm that I had anticipated. The chief objective was to explore whether a minimum of four of the eight program coordinators would be willing to work with me and possibly together during the coming year; we have acquiescence and agreement from that number, but the degree of clarity and enthusiasm is somewhat less than desirable.

V. Proposed Relevant Dimensions

At the next meeting of the program coordinators, Children's Unit, I intend to teach quite clearly through lecture and demonstration how to hold a problem-finding or problem-identification session. I will invite all of the program coordinators to attend, that attendance being voluntary; additionally each program coordinator will be invited to bring an additional key staff person from his individual unit staff. Thus, we may have as many as 16 people at the next meeting to be held Tuesday, November 7, 1972.

I called B, informed him of my most recent visit to Southside State Hospital and the proposal that I work with a minimum of four and as many program coordinators as were interested and willing, first on problem-identification sessions, then on problem solving, then on goal setting. Apparently

I have yet done nothing gravely wrong, since he seemed both to grasp the idea, express his willingness for me to work with his staff in this manner, and informed me how to reserve the Children's Unit conference room for that purpose. Additionally, he reported in glowing terms that he had recently been visited by some people from Health, Education and Welfare who had been quite impressed with his program and proposals for Children's Unit and satellite homes and the child care specialist training, those persons stating to him, "You are 30 years ahead of your time." He was exuberant, enthused, and eager to share his happiness. Additionally, he asked if I had seen the first issue of a new publication by the Department of Mental Health called exCHANGE, in which he has a feature article. He went on to give me the address of the editor, encouraging me to get a copy; he additionally asked if I had gotten from California Association for Mental Health their report on the task force on the children's sections at Napa and Southside; I had not, and he urged me to do so. I promised him I would immediately call Sacramento and get a copy of that sent to me. I did call CAMH in Sacramento asking them for two copies of that task force report as well as (since I am fortunate to know personally the secretary at that office) asking them to call over to another area in Sacramento and ask them to send me two copies of the new journal exCHANGE.

VALLEYVIEW BOYS CENTER (VBC)*

A. Summary Description of the Institution

Valleyview Boys Center is a children's residential center (CRC) housing approximately 80 educationally handicapped and emotionally and behaviorally disturbed boys between ages 11-15. It is located in a rural setting. The facility consists of four cottages (of two units each) which are several hundred yards away and quite isolated from an administration building, an on-campus school and a refectory. Most of the institution's operating costs are borne by the public agencies (primarily county welfare and probation departments) referring the children. In addition, there is considerable financial dependence on a sponsoring body, which makes up deficits in operating costs and pays off a mortgage on the property. The architectural design of the buildings and their setting are unusually attractive for an institution of this kind.

An organizational chart for Valleyview Boys Center as of August, 1972, when the consultation began, follows (see Table 5).

B. What the Consultant Thought He Was Trying To Do at VBC

The following statements of objectives, perceptions and strategies of consultation were prepared by the HIRI consultant to this particular institution, Harvey Ross, PhD.

1. Overview

I first visited Valleyview in 1972 during an exploratory phase of our project. The director, who then was quite new, described the 75-year-old institution as having evolved through a number of stages. It had been established as an Indian school to provide educational services to local Indian children who did not have access to schools in tax-supported school districts. As regular school districts came to serve more and more of the Indian children, the school was

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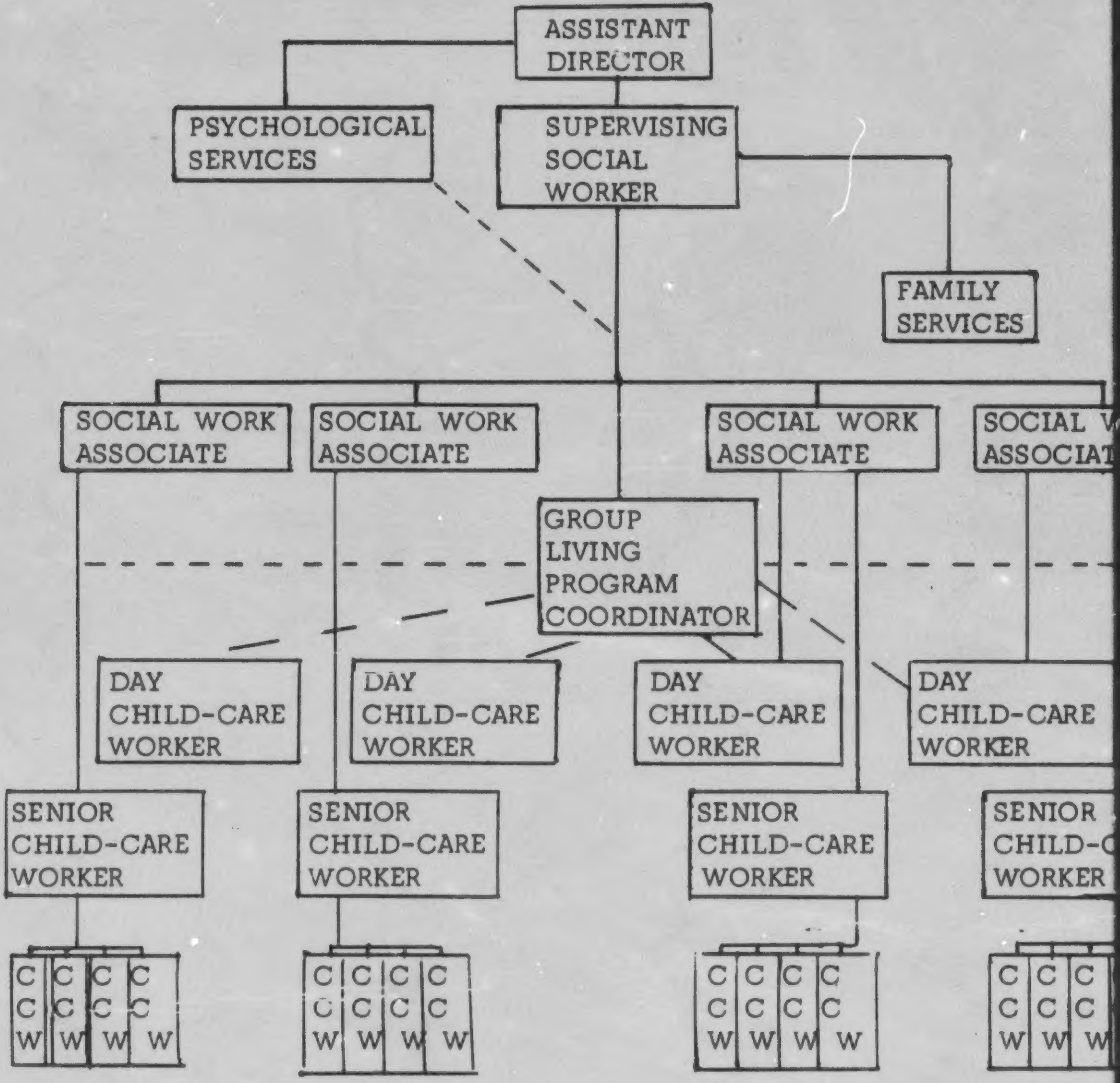
* This report on the VBC consultation and evaluation thereof was submitted for review of accuracy, etc., to the present director of Valleyview, and to the former director who invited the consultation. The present director felt--insofar as he knew--that the entire account was relevant, accurate and had his approval for publication as written. The former director felt that part C herein--the interview data gathered by the independent evaluator--should be omitted for the reasons discussed in that segment. Part B (as revised herein after consultation between Dr. Ross and the former director) was approved by the former as well as the present director. The remaining parts--A, D and E do not call for outside review.

Table 5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SOCIAL SERVICES

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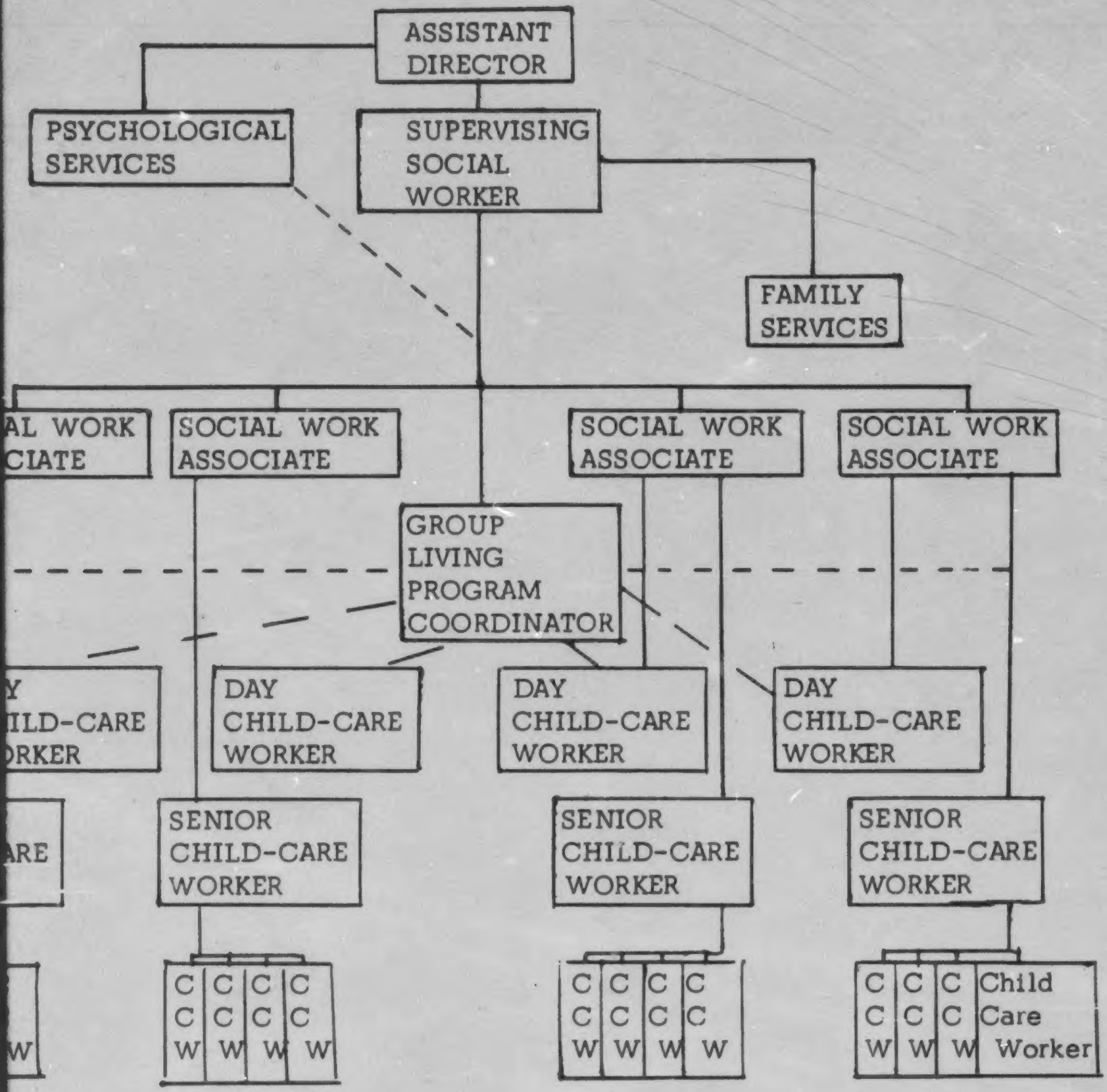
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Child Care Worker

SOCIAL SERVICES

converted to an orphanage. During the last two decades, it has evolved into an agency-supported residential treatment center for exceptional children, primarily serving a number of adjacent counties.

The makeup of the staff had changed in a manner parallel to that of the population served. Early in Valleyview's history, it was staffed primarily by members of religious orders. Gradually, the institution has hired increasing numbers of lay staff. The local school district recently has assumed responsibility for Valleyview's academic program as part of a federally funded special education program.

Like his predecessors the new director was a priest. Unlike them he had had experience as a mental health professional (he was a psychologist with an MA degree) and believed that the treatment needed by the current residents required a treatment-oriented, professional child care staff and a cadre of accredited social workers and psychologists. Accordingly, he was replacing the remaining tenured staff who still worked in child care with college-educated lay staff.

The director lived with important constraints: The board of directors restrained the freedom of the director to fire tenured staff and replace them with more educated and professional staff.

Before our first meeting, the director had considered closing the institution to rid it of staff members who resisted his attempts to professionalize and upgrade its operations and create a treatment program. The child care workers were a mixed group: Although some were experienced old-timers, turnover had been high and most were relatively new to the work. The differences of child-rearing philosophy, both within and among this staff were considerable. Compounding these differences was the influence of the few remaining tenured staff, who appeared nostalgic for the time when they were in control of the institution and could play a meaningful and satisfying role as nurturing custodians of what was then an essentially dependent (rather than disturbed) client population.

The difficulties with staff alone appeared almost unsurmountable to the director. Early in 1972 (about 6 months before the HIRI consultation began) he engaged two consultants to visit Valleyview, analyze its predicament and make recommendations for its improvement. They recommended radical revisions in staffing which would not have been acceptable to the board. If the director could have gotten permission, he would have closed the institution in order to start from scratch--gradually to train and build a new staff that would be able to conduct a treatment program. In effect, the director felt he could not make those recommended changes that might most directly and effectively have remedied the situation.

He adopted an alternative plan: to hire a number of professionals who would fill new staff and middle management positions and who would be given responsibility for supervising and training existing child care staff. Hopefully, and in time, they would be able to upgrade the quality of child care staff so that they would become willing and knowledgeable participants in a treatment program. The director, however, felt disappointed about the initial impact of the new professionals: They seemed very inexperienced (most had only recently graduated from college) and were surprisingly abrasive.

This, then, was the situation that existed when HIRI offered to provide organizational consultation as part of its own OCD-sponsored project. Valleyview was in deep trouble. The HIRI project director recognized that consultation would be a high risk venture, but elected to make his offer because the institution might add interesting diversity to the sample (the other institutions were much more stable). I agreed to go to Valleyview as its consultant, because I was interested in being helprul to the agency, if I could be, and felt that the experience, though it likely would prove difficult, might be a rich source of insights about the organization of CRCs and providing organizational consultation to them. The Valleyview director, hopeful about whatever assistance the consultation might provide, accepted the offer.

2. The Consultant's Perspective

My organizational consultation perspective is derived from a combination of experiences: a graduate education in psychology, some 15 years of training and practice in individual and group psychotherapy, case and staff consultation at children's residential centers, and 3 years of executive experience in a federal program, both abroad and in Washington. I tend to think about organizations in terms analogous to certain characteristics of a human psychological model and of my consulting interventions as having certain characteristics and objectives analogous to the activities of a psychotherapist dealing with an individual. Thus, among my most important consultation objectives is helping an organization clarify its own "identity" (mission, purpose and direction) and organize to achieve the goals implied by that identity. I want to help the organization mobilize its "ego" (responsible individuals and structures that constitute its decision-making and problem-solving resources) to overcome the organizational "pathologies" (areas of dysfunction in relation to its intended goals) in ways that are not likely to induce new "pathologies" as side effects from the intervention.

Whenever the opportunity presents itself and seems appropriate, I feel free to comment upon the styles of individuals, their interactions and group processes with the hope that increased awareness and insight increase possibilities for improvement. However, when interpersonal and intergroup conflict seems unresolvable through increased awareness of the nature of the conflict and through compromise, I then try to help the organization change itself structurally and change its processes to minimize organizational vulnerability to irrational attitudes and non- or anti-work related phenomena.

3. The Year's Experience and the Consultant's Strategy

I returned to Valleyview with a co-consultant (Jean Hall) in mid-August, 1972, to begin our consultation activities. We anticipated making about 30 visits over a 10-month period, averaging 2 or 3 days a month. Jean was to accompany me as often as possible, working as co-consultant and participant-observer. We planned an introductory phase devoted to information gathering and exploration which would help us develop a picture of how the institution functioned (and malfunctioned) in terms of its own conception of its mission.

Although our invitation from the director implied that we had at least some acceptance and credibility in his eyes, we believed that the rest of the staff might not similarly accept us if they perceived that we were (only) his consultants. A successful experience would require that we develop personal and working relationships and credibility with staff throughout the institution. In particular we would have to identify and work with those influential individuals and groups who constituted the institution's internal resources and embodied its potential for change and improvement.

The three most senior staff members were the acting supervising social worker, the psychologist and a staff person responsible for cottage program. These three staff members customarily met informally as a group--usually to discuss the problems and crises that were continuously being referred to them. Although they had no formal status as a group, we began to use them as our internal consultants, to orient us to the institution, to give us information about areas of strength and difficulties, and to arrange for our introduction to other individuals and groups in the staff. During these weeks, we attended a number of meetings with staff at all levels of the institution, including social work, cottage staff, and school staff.

While the director wanted to be informed about and participate in our consultation activities, he did not want to direct them. We initiated a pattern of meeting with him for at least a few minutes every time we visited the institution, to discuss our perceptions of the institution and opportunities for intervention it afforded, to listen to his concerns and whatever information he wanted to proffer; we wanted to provide as much support as we could to this director who was in a difficult situation. We assiduously avoided discussing individuals except as that could be done in an organizational (and neutral) context. We took care not to betray confidences, although we would request permission to relay information (to and from the director) when it seemed helpful to do so.

By the time we began our consultation visits, the director had become quite troubled by doubts about the competency of his new professional staff. Two of the three staff professionals had agreed to take responsibility for an in-service training program for child care staff, but had not succeeded in designing and implementing a program. (The director was particularly disappointed by what he felt was either their unwillingness or incapability to do so.) The third professional, although nominally a supervisor, did not accept supervisorial responsibilities; he preferred to involve himself in clinical activities, especially with families.

Nor did the director feel much confidence in the new middle managers, the social work associates: They appeared intent primarily on exercising authority over their units so that they each could put into practice what they had recently learned in school; in effect, to the director, each appeared to want to use the institution to do his own thing, without being interfered with by anyone. These and similar conflicts over authority and turf--manifested by a general reluctance to delegate, vest, accept or recognize authority--appeared often to be the theme of the considerable discord that plagued the institution.

Our initial visits at the agency had already brought to our attention several potentially destructive problem areas. The first problem was evident alienation among department and professional groups, and the dysfunctional effects of this on the agency. Second, we had observed that although the director frequently expressed his expectations to the staff that they take action to correct many of these difficulties, they appeared to be unable to plan and implement effective corrective measures. We were uncertain about the causes of their difficulty. However, the intensity of suspiciousness, reproachfulness and hostility was evident and extraordinary: between the director and his staff (even those whom he had recently hired); between the recently hired professionals and the cottage supervisors and cottage child care staff; and between the school teachers and the social work/child care staff. The child care staff felt that the professionals (social workers and psychologist) understood little of the realities of life in the cottages. Thus, the professionals' opinions were not sought by the child care staff in the development of treatment goals or interpretation of behavior because their interventions were considered intrusions. Last, there was a significant lack of integration between the school and the residential treatment component of the agency. The goals for each shared little common bond. In fact, the school saw the proper goals for the cottage staffs as maintaining well behaved, controlled boys that were educable. The cottage staffs, on the other hand, expected the teachers and school to be totally responsive to the treatment needs of the child. In addition two of the teachers (from the local school district) were openly hostile to the director and (he felt) tried to turn the children against the institution using subversive provocations.

Another organizational dysfunction we had observed early in the consultation was the agency's characteristic stance of reacting to crises rather than planning to avoid them. In fact, staff members spent such a large proportion of their time "fire fighting" that they believed they had not time to plan. We discussed with them the likelihood that their not making decisions and following through was responsible for their crisis orientation.

We discovered that, within a month, and just before the opening of school, there was to be a 3-day meeting at a nearby resort community to be attended by the school, social work, and senior child care staffs. The purposes of the meeting were to facilitate working relationships among these staffs and to make plans for the coming year at the institution. Believing that our attendance at these meetings could serve to develop and strengthen the consulting relationship, we expressed our interest and were invited to participate.

The agenda for the meetings covered such topics as how to orient staff filling the newly created "day child care worker" position; discussion about the use of monetary incentive by cottage staff to influence children's behavior; and an academic contracting program for child care staff which would provide individualized educational goals for each boy in placement. Although the meetings were intended to encourage collaborative planning, we were impressed by the extent to which planning was attempted by functional groups working separately (the child care staff, the teachers, the day child care workers), without involving representatives from other interested groups in order to create integrated plans that could be agreeable to all interested parties. On a number of occasions, we directed these groups' attention to the difficulty they were having in planning, attributed the difficulty to this faulty group composition and suggested that unilateral planning by one group for all would exacerbate antagonism and difficulty in communication. On more than one occasion, our comments resulted in decisions not to continue to try to make plans without consulting the other interested groups.

The unified school district teachers wanted to take advantage of the meetings to present their plans for a new educational program involving open classrooms and educational contracting. At the end of their planning meeting, in preparation for their presentation, we suggested that they consider combining contracting with the children for educational goals with contracting for behavioral goals. In that case, the contracting team would involve a child, a representative of his cottage staff, one of his teachers and a representative of the professional staff. The plan not only would have the merit of involving the child in his own treatment plan and in introducing the notion that the educational and treatment components were part of a unified effort, but it would bring together in a working relationship the cottage and school staff for whom the organization had not previously provided a vehicle for shared effort.

Even though this suggestion generally was well received by the professional, cottage and school staffs, and a consensus developed to implement it, the meetings came to an end without anyone taking responsibility for its implementation. We discussed this absence of follow-through with the staff, and suggested formation of a task force to take responsibility for planning, but they did not actively take steps to put the suggestion (or any other plan) into effect. (The projected use of the new day child care workers in fact further institutionalized organizationally the noncommunication between the school and the cottages, perpetuating the response to crises. Rather than participating in treatment teams that would include teaching and child care staff, and playing a positive role in an integrated treatment effort, the day child care workers were to function as messengers between the cottage and the school.)

Realizing that the staff-as-a-whole might not yet be able to organize to integrate their planning and activity in an orderly manner, we decided to focus our first efforts on one limited staff segment with which we might be able to work intensively to good purpose. We reasoned that if we could help one important work group develop the capability to make decisions and to follow through, it could become a model for the rest of the institution. A most appropriate group with which to start (and which already met with us rather informally) might be composed of the acting supervising social worker, the psychologist, the group living coordinator, the school principal (the senior staff) and the director.

During that period, much of the time and energies of those individuals appeared to be taken up in dealing with the many crises in the institution, mostly at the child care level, which typically were referred to them for solution. In large part, because they made no plans to minimize the likelihood of crises, crises did occur. Similarly, because staff members at child care levels had not learned to plan to avoid crises or make their own decisions to deal with them, they referred them for solution to the senior staff who then found their time monopolized by fire fighting and found themselves unable to take the time to plan. Bringing that group together as a senior staff--perhaps as a management team--might simultaneously have a number of beneficial consequences:

a. The director might be encouraged to share his authority and responsibility with his senior staff with greater confidence.

b. Greater reliance on the senior staff would be an important step toward helping them develop as responsible leaders and staff resources; if they felt more trusted and could depend upon freedom from what they perceived as the director's unilateral interventions, they might become more responsible and more willing to plan for the institution.

c. A management team that took responsibility for planning could serve as our consulting "audience" and counterpart in the institution to share in planning our consulting activities and to take responsibility for monitoring (or effecting) implementation.

d. We would try to help the new management team learn to become a resource to other work groups, to help those groups learn to deal with the areas for which they were responsible by orderly planning, and implementation.

We addressed this group (which already had started to call itself "The Advisory Committee") with our proposal. We proposed an agreement or contract: We would present them with a list of the issues in the institution about which we believed there was cause for concern; we would then make ourselves available to them and the rest of the institution to help them develop the capability for dealing with those and similar issues. In return, we asked that they: (1) respond to that list; (2) identify the issues that they felt were most important and with which they wanted to deal; (3) establish priorities among them; and (4) develop a collaborative strategy with us to address those issues. The group's decision to enter into this contract with us was their first attempt to make a planning decision as a group. On November 1 (our 14th visit) we presented our list of issues in accordance with the above arrangement:

a. The functions of the director vis-à-vis those of the managerial staff are not explicitly understood.

b. The internal distribution of responsibility and authority from managerial staff down through supervisorial levels and to line staff is somewhat unclear.

c. Even when individuals know (or believe they know) what their responsibilities are, they often appear not to know what to do.

d. Tendencies toward departmentalization appear to interfere with the ability of heterogeneous staff groups to focus on individual children.

e. In being crisis oriented, the staff is distracted from dealing with and developing a sense of institutional mission.

The Advisory Committee (including the director) agreed that the issues presented were the important ones that should be confronted. Although one or two members (including the director) identified what, in their opinion, were priority issues, they did not decide as a group what our priorities should be. Again, their reaction was consistent with the style of the institution. And again we pointed out that, while there could be agreement that an issue was important and deserved attention, they made little movement in the direction of making decisions and planning for implementation.

Their behavior seemed to indicate that they were unable or unwilling to try to make decisions, to plan and to work toward objectives at least in part because of their relationship with the director. Neither the director nor the staff had sufficient confidence or trust in the other to work together productively. We discussed, with the Advisory Committee, our perception that (in part) their conflicts appeared rooted in ambiguities which surrounded the responsibility and authority related to tasks within the agency. Responsibilities accepted with unclear conditions and which subsequently were not fulfilled were open to the director's unanticipated interventions, which often occurred as a result of pressure he was experiencing. The staff characteristically reacted by becoming passive and resistant to new responsibilities, hesitant to take the initiative. For the director, this passivity confirmed his fears that his staff was not capable of effectively developing the agency program, thereby encouraging his interventions. (In particular, he was at that time very troubled by a chronic deficit in their operating budget caused by low population. As he perceived it, his staff could take action to increase the population, but appeared not to be willing to share his responsibility.)

We discussed with the Advisory Committeee and with the director the possibility that they could develop a new relationship in which the Advisory Committee would take the initiative for planning and implementing programs to respond to the director's concerns. He might then be encouraged to turn to them as a helpful resource upon which he could depend. We speculated with them that, in some ways, it might be easier for them to continue a relationship with the director in which they could feel angry and abused and put upon rather than assuming responsibility and trying to take initiatives which might bring them into open conflict with him. While taking responsibility might enable them to be more effective and productive, it also increased the danger of open conflict (not only with the director but perhaps, with each other).

The next several weeks, we made a point of meeting with the committee every time we went to Valleyview. Each time the committee appeared to be behaving in a passive and complaining manner, we commented on their behavior in terms of the interpretation discussed above. We also tried to help them establish more orderly procedures with agendas, minutes, plans and assigned responsibilities which the committee could monitor. Although the director's attendance was somewhat irregular, the group made a good deal of progress. Indeed, by February, it had:

- established a task force to plan treatment teams and goal planning for individual children,

- helped the newly appointed MSWs and the social worker associates (the cottage supervisors who by then had several months' tenure) begin discussions aimed at developing a mutually acceptable statement of their relative duties, responsibilities and purviews of authority,

- initiated a program to repair and redecorate one cottage and provide in-service training to cottage staff to upgrade cottage performance in the area of treatment.

This latter plan originated with one of the social work associates and had the backing of his three colleagues. It was significant that they made the recommendation to the Advisory Committee.

This meeting was a high point in the development of the Advisory Committee. A concrete proposal that had staff support had been submitted. The director participated in the decision making and represented his own interests in that process but did not attempt to dominate it. The group decided to give the social work associate authority to implement his plan. The plan was not effected, because a few days afterward, the director's acute concern about a pressing issue led him, once more, to enunciate a number of decisions which the group interpreted as an infringement of the authority that he previously had delegated to them. On his part, the director felt that the group could not tolerate his justifiable activity because they could not accept proposals made by any authority figure and wanted to have unshared power.

The group regressed to their previous stance of complaining and passivity. We began to feel that we were involved in a losing game. We might make some forward steps during our visits, but between visits the mutually provocative behavior of the staff and the director would undo the progress made. We began to doubt that our strategy could succeed. Perhaps some other possibilities should be considered.

Our strategy had been based on a decision to try to work within the existing organizational structure. Thus, although we tried to strengthen the Advisory Committee as a working group, we were not making any profound structural changes since that group existed informally before we began the consultation. Similarly, we had attempted to work within the existing structure when we encouraged the social work associates and the new MSWs to try to work out their relationships and respective roles through discussion and negotiation with each other. Our experience with these latter groups illustrates the sequence of events that was making us uneasy about our strategy.

The four social work associates, who were college graduates, had been hired by the director the previous summer as part of his attempt to professionalize the program. Each was to have responsibility for the treatment program in two cottages. Theirs was the most important line supervisory position in the institution. All child care staff in their cottages reported to them. After being hired, each had proceeded to run his two cottages as a separate institution. Each did his own intake, planned and implemented whatever treatment was done and controlled the termination procedure. And each did these things in his own way. They did not meet as a group or plan together and were only vaguely responsible to the acting social work supervisor. At least partly because of this independence, the director had then hired two MSWs, apparently hoping that the introduction of more highly trained professionals would lead to the creation of an institution-wide treatment program with greater accountability from the social work associates. The MSWs' role had not been spelled out by the director. They were instructed to develop meaningful roles for themselves in the institution.

We had pointed out to the social work associates that they might now have to speak as a group if they wanted to establish an acceptable position and negotiate with the MSWs. For the first time, they began to meet and (as might have been predicted) they proposed rather peripheral roles for the MSWs. They were adamant about not accepting supervision from the MSWs. It became clear that this situation probably could not be resolved in the course of meetings at which MSWs and social workers tried to work out an agreement among themselves.

The situation became critical toward the end of February, 1973. The director had become impatient with the unproductive negotiations between the MSWs and social work associates and insisted that the two groups clarify their respective roles, or he would have to define those roles for them.

He also was having second thoughts about the plan to renovate the cottages and give in-service training to cottage staff which he, as part of the Advisory Committee, had already approved and which had begun to be implemented. A considerable investment of time (of both children and staff) and money had been allocated to renovating one cottage, and he felt that the staff was not properly maintaining the improvements. He was concerned that making further investments without some indication of staff commitment might turn out to be wasteful.

The staff reacted angrily. Once more (as they perceived it) the director had retreated from his "new" relationship with his senior staff and was imposing a number of decisions upon them. They reacted by again becoming preoccupied with their struggle with him for authority and lost their focus on planning. By this time, their loss of confidence in their ability to develop a good working relationship with the director made it seem unlikely that any further intervention on our part to strengthen the Advisory Committee could be useful.

A more radical approach seemed necessary--that is, an approach that would attempt to alleviate these conflicts by making basic changes in the organization that might remove (at least) the structural causes of them. We reasoned that if there were a way of restructuring the director-staff role so that their relationship would have to change--for example, by creating an associate director's job--the opportunity for conflict would be reduced. If the associate director could have some significant responsibility and authority for the internal operation of Valleyview while being accountable to the director in a way that would be satisfactory to the director, the director could turn his attention to the relationship between Valleyview and the environment, an area which deserved his attention. Furthermore, a structural change could bring about redefinition of the roles of the social work associates and the MSWs in a way that both could live with and yet apparently were unable to produce through negotiation. It was for those reasons, that, late in February, we suggested that the organization consider a workshop in order to overcome these anomalies as well as to create a staffing pattern that would enable team treatment to take place. Such a workshop already had been designed and carried out as an exercise by two of our consultants at two of the project's other intervention CRCs.

While the details of the method are not relevant to this narrative, the goals are. Briefly, the purposes of the exercise are to redesign the organization and the jobs within it to correspond to institutional objectives and the necessary tasks those objectives require; to make explicit the delegation of responsibility and authority from the director to other members of the staff; to agree upon accountability measures by which the work of staff members might be assessed; to teach the organization that it has complete freedom to redesign its own structure and redefine jobs whenever it wishes--and to teach a process of negotiation for coming to agreements about making such decisions.

We had first suggested the exercise to redesign the organization believing that it might facilitate the negotiations between the MSWs and social work associates. Now it began to seem necessary for the Advisory Committee, as well. Attempting to create an effective planning and management group by making adjustments within the structure of the existing organization apparently had failed because of the intensity of the existing authority problems. The director and Advisory Committee agreed to invite the two consultants who originally had designed the workshop to come to Valleyview as "resource consultants" to discuss that possibility.

The two resource consultants spent a day with us (the "primary consultants") at Valleyview to assess the appropriateness of their exercise for Valleyview, to provide more information to the staff and director about the exercise and to try to move toward general agreement about whether or not to proceed to develop a variety of the exercise that would be specifically tailored to the needs of Valleyview.

The behavior of the organization and its component groups with which we met was consistent with the organization's behavior in the past: The staff believed that the director was going to rely upon the exercise to produce a new organizational design, but was suddenly presented with a new design created by a staff assistant to the director which they feared was meant to preempt the exercise and the possibility of their participating. It was difficult for the director to convince them that he had had no such intention, but merely wanted to present the new design as a possibility, for their consideration.* There were many expressions of mistrust and suspiciousness both between groups and toward the director; the director's position toward the possibility of an exercise was interpreted as ambiguous by many staff members. No one seemed to know what would constitute a decision either to go ahead or not to.

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*Licensing agencies were pressing him to produce a table of organization, which he felt he could not give them while significant changes were being made. The director's design was intended as one concrete possibility, which the staff was free to accept or reject as long as they came up with some organizational plan that everyone could live with.

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The resource consultants stated their conditions for proceeding: that there be general consensus supporting the exercise and that the director and staff be willing to commit themselves to the outcome, whatever that might be. The outcome would be constrained only by whatever statement the director would make (before the exercise) describing some minimal requirements that the design would have to satisfy from his point of view. They attempted to help the director and staff clarify their thinking about the proposed exercise by describing the way the exercise had proceeded elsewhere and specifying what might be reasonable goals.

In addition to the characteristic difficulties of Valleyview in making decisions about implementation, there were realistic reasons why a decision about proceeding could not be reached that day. The director was naturally quite hesitant, not yet understanding what he perceived to be some risks in committing himself in advance to a new organization that would develop in the course of the exercise. He needed more information and time for reflection. He was reassured that the exercise would not require that he delegate more responsibility and authority than he wished and that he could decide which responsibilities he might want to delegate. Furthermore, as an additional safeguard he could state his conditions for proceeding. A meeting was arranged with the directors of two other institutions at which the resource consultants already had carried out similar workshops. The Valleyview director had an opportunity to discuss with them his questions about the issues, risks, and benefits he should take into account while making his decision.

In the course of subsequent visits, we were able to provide the director and his staff with enough additional information so that they were able to come to a decision to go ahead with the exercise. The director made his conditions for proceeding explicit: that there be a significant consensus to proceed among the staff; that the reorganization would involve no additional costs; that whatever the assignment of responsibility and authority, there be a corresponding accountability and that the resulting organization should provide a basis for the treatment of the children by staff teams, each of which should include representatives from the professional staff, the child care staff and the school staff.

The resource consultants, after spending two more days at Valley View to orient staff and design an appropriate exercise, carried it out during one very long work session at a nearby hotel. In order to limit the size of the working group to a manageable number, they had decided that the first workshop should not include the line child care workers or the teachers. These groups would be represented by observers but would not participate in the negotiations for responsibilities during this first phase. Since delegation proceeds from the director "downward" to an associate director, and thence to the professional and supervisory staff before any responsibilities are delegated to line child care and teaching staff, this limitation was reasonable.

As a result of the day's negotiations, the school principal became the institution's associate director (a job which did not exist before the workshop, and for which the principal nominated himself) and a good deal of sorting out of responsibilities occurred for the professional and supervisory staff. The problem of the MSWs and social work associate staff was resolved by the creation of a new position, "treatment team leader." Each of the four units would have a treatment team leader whose primary responsibility it would be to plan and monitor the treatment of each child in the unit. One of the MSWs replaced a departing social work associate and the other elected to assume a number of responsibilities of a staff nature (intake, family contact, etc.). The new organization embodied a treatment team concept so that for each child a child care worker, a teacher, and the treatment team leader would share responsibility with the child for planning treatment and implementing it. A new job, unit supervisor, was created to manage each unit administratively.

It was clear, at the end of the exercise, that a good deal of negotiation and working out of details remained to be done. Further steps to negotiate the responsibilities of child care workers and teachers would be required. Ambiguities and unidentified responsibilities to which no one had laid claim would have to be resolved. However, since the resource consultants had presented the exercise as a learning experience, rather than as one resulting in an immutable organization, they had made it clear that the staff should expect to continue the process on their own in the future.

Although both we as the primary consultants and the resource consultants offered to continue to make ourselves available during the coming month to help deal with residual issues, no one in the organization requested our further involvement. During a subsequent visit it became apparent that the new associate director and the staff were attempting to take hold of their new jobs and were not ready to use further outside consultation. Thus, the day of the exercise proved to be the end of the active phase of HIRI's consultation at Valleyview.

4. An Assessment of the Impact of Intervention

During a visit to Valleyview about 6 weeks after the workshop we tried to assess the impact of the consultation on the agency. We realized that some changes might have been set in motion relatively early in the consultation while others would stem from the intervention made at the time of the exercise. The following is our best effort to identify the most significant changes we had the opportunity to observe during that day's visit.

It was clear that the associate director was doing his best to master his new role. On the one hand, he was still negotiating for and attempting to establish the boundaries of his responsibilities and authority within the institution--all in relation to the director. He and the director were in disagreement about the purview over which he had been delegated authority. Although, as part of the exercise, the director had agreed to delegate some responsibility and authority for internal management to the associate director, they apparently had not actually come to a meeting of the minds. The associate director believed that the director had agreed to delegate to him most or all responsibility for internal management. The director, however, had intended that the associate director take responsibility only for the treatment program. In time, the new associate director might prove himself sufficiently to the director to be delegated more authority, but he would have to overcome the director's cautiousness with a sustained effort in order to succeed.

On the other hand, the associate director was preoccupied with establishing basic administrative patterns--primarily in the areas of record-keeping and accountability. His new responsibilities would be unmanageable if he did not first establish some procedures which hitherto had not existed. His preoccupation with administrative matters had kept him fairly isolated in the administration building, preventing him from becoming involved in the area in which he had expressed deepest concern: the establishment of treatment teams. We suggested that even though he had engaged a consulting psychologist to help train the staff to operate in teams, his personal leadership and involvement would be required if the staff were to implement the treatment plan in a wholehearted manner.

In fact, a very uneven implementation of the treatment team concept was taking place. One cottage had made considerable progress. It was in the process of drawing up individual treatment goals and plans for the children. In another cottage, there had been no perceptible changes. Child care staff was complaining because the new emphasis on accountability had resulted in the proliferation of new forms. Apparently to some of them, accountability meant more detailed accounting.

In the school, a new "educational services coordinator" had replaced the principal. The new title implied a changed conception of the job. The new school director was responsible for integrating the services of the school with those provided by the institution as a whole. The new coordinator was highly committed to the idea of a treatment team in which teachers would play an important role. Although it was summer, and regular school was not in session, he was in the process of assigning children to the summer school teaching staff. Each one would have a group of children in whose treatment team they would play an important participating role. He was encouraging the teachers to establish a new kind of relationship with the children that was more akin to a supportive counselor than to the role of disciplinarian which most had played under the previous arrangement. Since these changes still were in a planning stage, we could not assess to what extent they might be implemented in the future.

Valleyview, like all other children's residential centers in California, was anticipating the state's mandate that they do goal setting for each child and provide some measure of progress. On numerous occasions we had discussed this problem with the institution's director and staff, and had encouraged their involvement in the state's organization efforts to develop an acceptable procedure. During the course of our consultation we had arranged a visit by an outside expert experienced in the techniques of goal setting to discuss goal setting and help orient the Valleyview staff. Since its reorganization, the agency had engaged a consulting psychologist to help it establish a record-keeping and evaluation system, an indication of the agency's commitment in this area.

The treatment team leaders were now planning and working as a group much more than they had done when they were social work associates at the beginning of our consultation. One of their members stated that our consultation had demonstrated the value of working as a group and they had continued to do so even after their jobs had undergone some changes in definition. The agency's working groups had apparently learned to manage their meetings using agenda, explicit objectives, and minutes. This style of operating probably would be self-sustaining since it tended to be self-reinforcing.

All of the above indicated movement in desirable directions. However, some of the changes--particularly those that had occurred in the organizational area as a result of the workshop--still appeared fragile and would have to be supported by strong leadership and a good deal of follow-through. We left the institution feeling that it now would really be ready for the support of external consultants.

C. What the Independent Evaluator Reported, Based Upon His Interviews at Valleyview Boys Center in November, 1973, Three Months after Completion of the Consulting Intervention

This report was submitted by Roland Wilhelmy, PhD, the independent evaluator.

1. Assignment

To meet with certain staff members and former staff members of VBC, to assess and report on the changes that had taken place there since August, 1972. The prime focus of my investigation was the impact that HIRI's consultants' actions had had, but I was also interested in all significant changes regardless of how they came about.

2. Procedure

I spent one day at VBC interviewing the staff. I also spent part of another day interviewing former staff members. Interviews lasted from a 1/2 hour to 3 hours each. The interviews at Valleyview were conducted at the individual's place of work. The interviews with former staff members took place in one of the staff members' homes.

Because of the abrupt changes in administrative staff, including replacement of the director and assistant director, as well as the turnover of more than two-thirds of the entire staff, my interviews at Valleyview were less structured, more openended than at the other children's residential centers. Each interview began with an openended question asking the respondent to help the interviewer list significant events or changes. Where necessary, I asked additional questions regarding which changes effected by or through the consultant seemed most important. In addition, I asked them to describe ways in which the client-consultant interaction might have been strengthened.

I also had a checklist of items which, on an a priori basis, seemed to be important to investigate. In separate interviews, I met with the associate director, the social service coordinator, the educational director, the school counselor, a former psychologist and a former group living program coordinator.

3. Special Environmental Considerations

On August 22, 1973, a new associate director was installed at Valleyview. (The new associate director was a layman, with an M.A. degree and working toward a PhD. He reported to an executive director, who spent only part time at the institution because he had other responsibilities.) In the 3 months following that event Valleyview was completely reorganized. Every single position was reevaluated, different sets of roles and responsibilities were instituted in many jobs, more than two-thirds of the staff were replaced, one of the cottage units was closed down, and schooling for those children taught by the school district was moved from some old Valleyview buildings back to the new Valleyview campus. In short, it would be difficult to find a single individual or a single procedure which had not experienced drastic change in the preceding 3 months. A number of employees were terminated under less than friendly circumstances. Some child care workers walked off their jobs in a dispute over working conditions and job security. These and other disputes were covered widely by area newspapers. The result was that Valleyview was an extremely polarized institution. Mobilized for action by having to face a common crisis, the remaining employees, many of whom were new to VBC and therefore not involved in the previous power struggles, seemingly had pulled together, and appeared to be operating with a clear idea of what they were trying to accomplish.

This was not a situation in which it was possible for an interviewer to elicit reflections on the way things might have been under different conditions. The immediate situation demanded all of the resources the institution could command. The people I interviewed at Valleyview were friendly, cooperative, and took considerable time out of what must have been an extremely busy schedule in order to tell me about what they had done. But they were so immediately involved with such a recent series of changes that there was no way that they could be expected to give a balanced report on the way Valleyview had been before the changes had been instituted.

In a very real sense, this is the report of two institutions--one, VBC before August 22, 1973, and another, the Valleyview following August 22, 1973. The institution that HIRI's consultants worked with no longer existed after August 22--with no judgment implied here regarding which might be "better." There are a few residual indications of the consultants' efforts but these resemble the residues of

Christianity in Constantinople following its takeover by the Muhammadans. Many of the changes to date appear to constitute a promising beginning by a new team, but they have little relation to the institution which received 1 year of consulting work. (Under thse conditions one might understandably argue that no useful evaluation-by-interview could--or should--be undertaken because the great majority of currently employed respondents had no first-hand knowledge either of the old VBC or the consultation. Under the circumstances perhaps what has been said above is all that can be reported as objective fact about the HIRI consultation intervention at VBC--a viewpoint which was offered for consideration by the independent evaluator. The project director's rationale for conducting interviews at VBC in accordance with the project evaluation plan for all four institutions, despite this caveat, was that some few persons interviewed *were* present during the consultation. Further, it would be of interest to obtain the perceptions--for what they might be worth--of the newcomers regarding the institution as they found it and the problems *they* felt needed priority attention.)

This HIRI project director is interrupting at this point for "station identification," so to speak.

As stated in Chapter I on *Project Purposes* and in Chapter II on *The Consultation Intervention*, a major purpose of the project was to test the hypothesis that:

> If fairly intensive technical assistance consultation (25-40 site visits in a year) aimed at getting an organization to reexamine its goals and evaluate the efficacy of its programs for goal attainment can be provided to child care institutions which invite it, this effort is likely to result in improved organizational efficiency and improved effectiveness in providing a constructive developmental experience for the children entrusted to its care.

and that:

> The overall purpose of the various convergent evaluation procedures has been to obtain evidence regarding two factors: (1) *Internal validity*--did in fact the experimental interventions make a difference (did they have demonstrable impact in relation to their purposes) in each institution and in the group of four that received the consultation intervention? (2) *External validity*--to what populations, settings, treatment variables and measurement variables can this effect be generalized--what can be learned from this study that might be of generalizable value?

The interviews by the independent evaluator with staff members at each of the four institutions regarding changes the interviewees at each institution could identify that in turn might be traceable to the consulting intervention...constitute one of the major pieces of evidence relevant to assessing the impact of the consultation, judging the relevance to child care agencies of various consulting modalities, and determining what can be learned from the experience. Those interview responses provide perceptions of the impact of the consultation on the modus operandi, effectiveness and efficiency of the given institution in relation to its child development purposes.

In the case of Valleyview, we encountered a special and unexpected problem, described above, which calls for a thoughtful judgment about the extent to which we properly can/should report the data collected by the independent evaluator. Some of the persons interviewed, such as: (1) the post-August 22, 1973, hires, some of whom perceived themselves as "rescuers" or "redeemers" of the preceding situation, thus were both negatively prejudiced about the former administration and had no firsthand experience with the HIRI consultation, or (2) persons tracked down from the previous staff who had been fired or resigned, but had personally experienced the consultation intervention...Two persons in the latter group said things to the independent evaluator that reflected negative and hostile feelings. Question: What is our ethical research obligation on the one hand to report the responses, biased though they might be, and on the other hand not to give space to what may be self-serving disparagements of individual predecessors?

Our decision with regard to this problem has been to delete personalized attacks, while retaining relevant inputs that represented legitimate viewpoints (albeit not necessarily "truths") about the institutional climate and the impact of the HIRI consultation. These perceptions, if we can interpret them in context, perhaps can lead to some important inferences about the HIRI consultation intervention. Perhaps these inputs could shed light on what did or did not seem to work out well, why one or another approach was successful or abortive. Such data could significantly enrich speculative analysis regarding what "might have been done" for use in future consulting applications.

(End of interruption)

4. The Interviews

a. Major Events about Which I (the Independent Evaluator) Hoped to Evoke Staff Response

In preparation for my visit to Valleyview I had read the consultant's reports and had met with the consultant and others at HIRI associated with the consultation. I had prepared a list of major consultation interventions of which I hoped to find some traces at Valleyview and which I would expect former Valleyview staff would be able to recall in some detail. These events were:

(1) A workshop on job responsibility renegotiations

(2) A seminar on individualized goal planning for each child

(3) A number of steps toward improvement in meeting efficiency: i.e., agendas prepared in advance, minutes kept and relevant people in attendance

(4) Work on improvement of relations between staff and director

(5) Processes for learning to resolve conflicts

(6) Instigation of child-centered team treatment involving the children in treatment planning

b. Interview with Person #1*

My interview with Person #1 extended over more than 3 1/2 hours. Most of the talking took place in his office. He began by explaining that the executive director plays a largely ceremonial role and is not involved in day-to-day administration except under unusual circumstances in which the executive director is the focus of ultimate appeal.

When Person #1 first arrived he analyzed Valleyview and then met with HIRI (about 3 months after the HIRI consultation was terminated). He explained to me that he was interested in obtaining respect, not popularity, and that his concepts of negotiation differed from those of HIRI. He felt that negotiations are sometimes valuable, but only for higher level professional staff. He felt that low level professionals operate mostly from emotion and were not capable of achieving good results through negotiation. He said that HIRI's negotiation workshop exercise had "led to some girl with a B.A. in philosophy becoming a sociological coordinator." Negotiations of this type could lead to incompetence in all staff positions. Negotiations had resulted in two people having the final authority in each unit. Both the treatment team coordinator, who was a social worker, and the unit

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* This person, in turn, left about 6 months later.

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supervisor shared final decision-making authority. With this mutual authority there was no one finally and ultimately responsible for the unit. When he asked the treatment team coordinators to come up with a statement of their philosophy, a description of their operation and how money was spent, he got massive resistance.

After he had studied Valleyview, he felt that there were four major problem areas. His approach was to deal with all four areas at once. The areas were: (1) the cottages; (2) the school; (3) the physical plant; and (4) accountability and communication among all the staff (including the school) in the whole of the institution. He closed down the dirtiest, most poorly managed cottage and moved the children into the other cottages. He dismissed the staff of the closed cottage but gave them opportunities to apply for currently available job openings in other cottages.

The educational system in Valleyview involves some teachers from the local school district who deal with educationally handicapped children and some teachers employed directly by Valleyview. According to Person #1, the school district got a large amount of money for serving educationally handicapped children, but there was some question in Person #1's mind regarding how much of this was spent on the educationally handicapped children. Person #1 regarded this as a question or problem he was checking into.

Evidently a number of the school classes (electronic shop and models) were being held in the old, dilapidated buildings of the former Valleyview location. Person #1 canceled all off-campus schooling unless it was for children who could not attend the regular school classrooms. He found room on campus to expand the on-campus school. He completely revised the purchasing procedures in the school. He stated that he instituted a program of cleaning up the kitchen, dining halls, classrooms and cottages, and improved the recreational facilities and landscaping. He declared a moratorium on admitting new children until the conditions for the present kids were at a level consistent with the environment he would like his own child to experience.

When Person #1 had asked the social services and educational directors to provide their own job descriptions and to evaluate their employees and rank them, they refused. He responded by redefining both jobs and asking each person to reapply for the new position. Neither person applied.

He expanded the recreational program, as well as facilities, especially in the evening. He obtained a new athletic director, a woman, who organized effective volunteer assistance in the program in addition to further organizing team sports and activities as well as individual sports.

He also claimed that he improved the financial situation of the institution. He brought in new directors for education and social services and began to rebuild Valleyview into what he expected would become a more effective treatment center. The new social services director and educational director worked together to achieve cooperation and communication between the cottages and school so that both groups could function in concert on agreed upon treatment goals and procedures.

Since the person being interviewed was not at VBC during the consultation, it seemed inappropriate to query him about his reactions to events which took place during that period of time. What is reported here is Person #1's view or perception, which is relevant for what it may be worth, but no more than that. (Comment by HIRI project director: The justification for describing changes made by a new post-consultation director, even though this recital is not directly connected with the HIRI consultation effort, is to present a picture of what he thought was needed to revitalize VBC. But more important, the purpose is to indicate the many changes that a new director can make when he isn't burdened with a legacy of longstanding staff conflicts and hostilities--when he can have a staff that at least starts with a fairly good degree of acceptance for his leadership style and modus operandi.)

c. Interview with Person #2

Person #2 was responsible for intake and outside liaison, although he emphasized that no one at Valleyview was stuck in a particular role. He stated that the new Valleyview staff operated in a spirit of trust and communication in achieving the aims of Valleyview. In addition to intake and outside liaison, he administered the levels program* and supervised the treatment team coordinators. The treatment team coordinators had been made ultimately responsible for everything that went on in their units.

Person #2 claimed to have increased direct contact between the cottage and the school. He encouraged staff visits of one to the other, and did his best to maintain daily open two-way communication. He felt that the agency was now beginning to treat children. The goal was school and cottage staff cooperation as treatment teams working toward specific goals for specific children. The advancement of a child from one level to another was determined by a committee decision based upon checklists of various kinds of behavior prepared by cottage and by school staff.

Person #2 felt that Valleyview was now more clearly child oriented. The administration attempted to obtain and maintain a kid's eyeview. The agency viewed moderate levels of anxiety as motivators for improvement. Teachers from the school district seemed reluctant to make changes, according to this respondent. They felt isolated at Valleyview. In response to these difficulties he was attempting to to change the school program and to give more support to district teachers by providing crisis counseling for the children.** Valleyview was sponsoring psychiatrists to work with clinicians at the institution so that emphasis was on treatment and therapy rather than on seeing themselves as an extension of the probation department.***

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* The levels program was a system of increasing privileges and opportunities in response to the child's increasing cooperation and ultimately his altruistic behavior.

** This person was not accurately informed about the previous arrangements. Crisis counseling had been available theretofore from the day care workers.

*** This gives an inadequate impression about the therapy program at Valleyview. As one of the consulting psychiatrists wrote: "Granted that at no time was a psychiatrist employed full time, nonetheless psychiatric coverage has been on a regular basis for over a decade...During the time of the former director's tenure I was at the institution every week, and always available by telephone. I insisted, as a routine practice, that for every boy I saw I had a conference with either the boy's social work assistant or his child care worker. (It was also routinely as hard to get the worker into conference as it was to get the boy in.) I attended innumerable meetings and conferred with individual staff members. I always terminated by communicating my opinions to the director... In August of 1973 I...tendered my resignation because I considered that further attempts to work with a staff so utterly capricious about even the giving of prescribed medications was an undue hazard to my professional position."

d. Interview with Person #3

Person #3 was one of the few now present who also was present during the consultation. The picture she presented regarding the current situation reflects her view of some of the things that needed attention earlier, perhaps during the consultation.

Person #3 described her perception of the situation before her arrival: There were just classes and teachers, with inadequate structure. Even the class schedules conflicted. Children's classes taught by district teachers met from 8:30 to 1:30. Because Valleyview school ran until 2:30, the district-taught children were left with an hour of nothing to do. Communication with the school district was "warped."

She changed the schedule of the school so that all children attended classes from 9:00 to 2:30. The school day consisted of six 40-minute periods with a 5-minute passing period in between.

Smoking continued to be a big issue with the boys. In order to resolve and rationalize the situation, smoking was permitted at certain times and in certain places.

The curriculum included science, algebra for those who were prepared for it, mathematics, language arts which included reading and composition, automotive shop, physical education and art, which included art practice and art history. (According to the former VBC director, the earlier prior year system had been individual contracts.)

In order to increase school attendance, an after-school study hall was instituted and students who missed class were required to make up absences during study hall. It was used solely for this purpose, not as an all-purpose threat. This procedure was instituted recently and seemed successful because the number of students in the study hall had dropped from 50 to 10 in several weeks. The system was not used mechanically. For students who were unprepared to be in class at all, other steps were taken and counseling was provided. As a last resort, "contracts" were concluded wherein a child would not have to attend a specific class provided that he maintained attendance at the other classes and performed his other duties in a satisfactory manner. The plan was first to get the children to attend classes, then to try to teach them (as had been done under the previous administration). The staff hoped to institute a greater number of field trips and other activities than heretofore as more positive reinforcers for the children.

Since children need something besides school, athletic programs were set up. There was a football team, which involved about 25 of the boys. The team set up its own rules specifying what was required of each member, and it was planning to complete the season with a banquet and administration of trophies and awards* later that week. The agency also expected to have a basketball team during basketball season. From 6:15 until 8:15 each evening they had a recreation program which involved both team and individual sports, music, various kinds of craft work and other activities.

Both in the school and in the recreation and athletic programs, Valleyview tried to avoid setting the child in any situations where he was likely to feel a sense of failure, or feel backed into a corner by an authority figure. If the child were judged to perform inappropriately in some way, the staff wanted to make sure that the criteria for satisfactory performance were objective and relevant to the requirements of the situation, not the arbitrary requirements of an authority figure.

Person #3 felt that this had been a difficult time for the children because of all the changes in staff and procedures. Her goal for the future was slower change through growth, not through so much rapid change. The agency had experienced a period in which new policies and new procedures were instituted. In the future they hoped to consolidate these, and to modify them as seemed necessary or appropriate. (Comment by HIRI project director: The relevance of including these details from the interview with Person #3 is partly because she was one of the few remaining on the staff who was present during the HIRI consultation and partly to indicate the many changes that can be instituted when a staff is actively engaged in reexamining its goals and programs rather than in rear-guard actions and paralyzing power struggles. It is surprising that this interview did not yield direct information about the impact of the intervention by the HIRI consultant).

3. Interview with Person #4

She was present at Valleyview during the time the consultants were there. She felt that HIRI had started to get things organized, and thus had been helpful. Some of the job descriptions remained the same. Treatment team coordinators, unit supervisors, and counselors were still there but under the new administration, things were more unified. There was more communication between teachers and counselors, things were accomplished now.

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* This had been an annual affair, with outings for immediate reinforcement.

Person #4 felt that staff could now talk with the administrators and that the administrators had more trust in the counselors. Previously the counselors had in a sense been glorified babysitters; now there were treatment programs and they were involved in them. She talked of the improved morale of the staff now that the interpersonal conflicts had been reduced, and of their hopes for the future. (Note by project director: Again, confirmation of the enhanced possibilities for creative accomplishment and constructive change when the situational climate encourages critical review of program effectiveness in a spirit of adequate mutual trust and ego involvement in trying for a renascence.)

Follow-up of Former Employees

After my visit to Valleyview I attempted to contact a number of former Valleyview employees who had been present during the consultation. I found it extremely difficult to locate any of them, but eventually I was able to set up interviews with three of them.

f. Interview with Persons #5 and #6

Their point of view of Valleyview was important and unique, but they were employees who were discharged from VBC, for whatever coloring that may add to their views. They, together with the acting supervising social worker, comprised the group, which I will for brevity refer to as the trio.*

When HIRI's consultants appeared at Valleyview, they were met with some hostility for several reasons, according to the trio. First, the consultants never made it clear (according to the trio) what they were trying to accomplish besides observe. This wasted an awful lot of Valleyview's time. Second, and relatedly, the trio constituted an already existing group trying (in their self-perception) to accomplish many of the same goals of HIRI's consultants. The trio had already held workshops. They had plans, already begun, to involve the administrative, educational and line staff in various cooperative ventures, and along came HIRI. HIRI worked through the director (project director's comment: as should be the case, both because the director is in a key position and because he is the person who invited the consultation, and wanted personal feedback on his own functioning) not through the committee or the trio. The consultant seemed to protect the director and isolate him from the trio and from the rest of Valleyview. This kept the trio from accomplishing as much constructive change as it had before the consultants appeared on the scene.

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* This was the nucleus of what the consultant refers to as the Advisory Committee (See Section B. 3., p. 139)

The trio saw themselves as having brought pressure to bear to get people out in the open, develop communication and establish a cooperative nonhierarchical team approach to treatment. Before the consultants had appeared, the trio had established control over much of the internal activity at Valleyview. While they could not affect what resources were available to them within Valleyview, they were able to allocate these resources in a relatively efficient way.

When the consultants arrived at the agency and spent a lot of time with the director and less with the trio, the trio felt that this weakened their position. They felt that neither the consultants nor the trio realized this at the time. It was an inadvertent result, but one with serious consequences. By October, 1972, the trio felt more comfortable with the consultants. They saw an opportunity to decentralize power through the consultants' efforts. Between October, 1972, and June, 1973, the relationship between the trio and the consultants mellowed. They wished, in hindsight, that that relationship could have been maintained for several more months but without the workshop and negotiations. Person #6 said that he had learned from the consultants how to look at problems, how to listen, and how to be quiet and let someone else explain things.

As did the other children's residential centers, Valleyview confused the role of the co-consultant. Her role wasn't exactly clear. Some people saw her as a consultant and then were puzzled when she didn't appear as often as the consultant did. They felt that sometimes the consultant came in from a theoretical orientation of his own, and they didn't understand him, especially the line staff. The line staff included child care workers, unit supervisors, teachers, teacher's aides and others except for professional or administrative staff. The trio felt that HIRI should have brought in people who could communicate with the line staff. (Comment by the independent evaluator: I should note here that the trio's responses echo those of the present associate director in evaluating the impact of the consultants upon the line staff. Although their interpretations and proposals for correction are different, their perceptions of the results are strikingly similar.)

During the period from October to June the trio did learn a number of things and there was some progress made in working with the director. This progress stopped when they got to matters of finance. The director was never willing to tell others about how much money came in, where it went and what the salaries of different people were. He was unwilling to delegate responsibility for spending money to anyone else.

They felt that HIRI had participated in two drastic mistakes. The first concerned the January 28, 1973, visit by the outside consultant on individualized goal planning.* While the results of this presentation at Valleyview helped, after his visit, the consultant wrote the director a letter regarding the creation of an administrative assistant position. That recommendation was a mistake; the person placed in the position of administrative assistant was not competent.

The second drastic mistake had to do with the negotiations of roles and responsibilities. Two other HIRI consultants were brought in. The new consultants were described as "loveable fascists" who jammed the negotiations down their throats. When a person who was not competent was installed as administrative director or assistant director, the VBC psychologist quit. (We have been advised that, as a point of fact, the psychologist was informed by letter while she was on a vacation trip that contract arrangements were being made with another group, and therefore her services would no longer be needed.) They felt that everything the trio and the consultants had been working for, for more than a year, had been vitiated by the negotiations. They felt that the workshop negotiation session "killed" Valleyview. While HIRI's consultant and the trio had been working on a cooperative, non-hierarchical organization, an absolute and perfect hierarchy was pushed down their throats by the new consultants.

One of the minor irritations (to the trio) during the consulting year was that the consultant met with the director at the beginning and end of each consulting day. This resulted in the consultant interrupting ongoing meetings in order to meet with the director from time to time. The trio never were really sure what was communicated to the director during these meetings with the consultant and were never quite clear as to the role the consultant was playing. On the other hand, they did find that the consultant was able to insinuate ideas to the director and lay groundwork for other future events that the trio was trying to accomplish. They felt that there was considerable investment by the consultant at Valleyview and that this investment made it difficult for the consultant to understand the trio and understand what was wrong with his relationship with the trio.

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* The worshop on individualized goal planning for each child was offered to each of the four institutions in the consultation group--with the HIRI research grant covering the cost. All four of the institutions accepted this opportunity, thus the consultant was invited to come west and present his material.

They felt that the children's needs weren't put foremost at Valleyview, nor were they put foremost by HIRI's consultant, and that the consultant's efforts were designed mainly to deal with staff problems (which the trio apparently felt would not necessarily lead to improved attention to the developmental needs of each child).

When Persons #5 and #6 were asked what was the most important thing the consultation had accomplished, the response was that they were making considerable progress in developing a dialogue between the school and child care staff, but that they got distracted from this by role negotiations. They felt also that HIRI had uncovered the serious dysfunctions of the institution and the fact that these dysfunctions were not correctable or resolvable was not HIRI's fault.

They felt that there were a number of problems at Valleyview with which the consultation did not deal; or perhaps the consultant was unable to deal with them. One of these had to do with relations between Valleyview and the school.*

Their consensus was that there was no way in which the consultation could have resurrected Valleyview, and that making Valleyview's difficulties visible to itself was a service, because it brought termination of a situation that was psychologically destructive to staff and children.

A final comment by the trio: They remarked that the consultants may have provided emotional and moral support to some of the staff at a time when it was too late, and this support in the form of optimism about things having a reasonable chance to get better may have increased the heartache by encouraging some staff members to stay around because HIRI seemed to imply that it knew something or had some special influence which would result in improvement. The fact that everything did not turn out to be all right made such encouragement (from the viewpoint of the trio) inappropriate.

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*Comment by the co-consultant: The consultants never considered the school as separate from the institution. Interventions which dealt with the organization included consideration of the school, e.g., the principal was included on the Advisory Committee; it was always suggested that teachers be a part of any treatment team; it was suggested that academic contracting in the school be communicated to cottage staff and possibly extended to include behavior or treatment planning.

In summary, the trio felt that HIRI's intervention was a step backwards because of the last minute negotiations of roles and responsibilities and because the trio's work had had some positive results through the summer of 1972, prior to the consultation. These results were undermined inadvertently by HIRI because the consultation worked to strengthen the director's hand and interfered with the trio's accomplishments, such as they were. Neither HIRI nor the trio really understood the fact of this conflict at the time. The trio thought that perhaps the director had used HIRI's consultation for his own purposes. They pointed out that he bragged about Valleyview's selection from 13 possible children's residential centers nationwide, and he talked often about the fact that they were getting $65,000 worth of consultation without cost to VBC.

The recommendations of the trio were that HIRI investigate more carefully before sending a consultant to a particular children's residential center, that provision be made for auxiliary consultants to provide communication between the consultant and all levels of staff with whom he planned to work, and that some contingency planning be done so that HIRI could withdraw consultation from the situation where such withdrawal was warranted.*

g. Interview with Person #7

Person #7 perceived that in July, 1972, there was a general feeling that a lot of changing needed to be done, but there was no set as to what to do or how to do it. In retrospect he could see a "polarity" as to what Valleyview Boys Center should be. The lay staff had a certain stake in change and progress, especially certain individuals. On the other hand, there was a great deal of distrust and suspicion by those in the religious order regarding the role of these lay people.

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* Project director's comment: This is an interesting and valid point. The HIRI project team, however, including of course the five consultants, did receive and in turn critique the Activity Reports from the other consultants, and did meet together about every 2-3 weeks for problem and project review, and to serve as critics to each other. Many intervention strategies used by each and all of the consultants were queried and challenged. The question of withdrawal from certain situations under given conditions was discussed.

The history of this conflict between lay and religious groups went back about 10 years. The tenured staff wanted to operate VBC as an orphanage, in other words to provide simple custodial care for boys. The lay staff was interested more in providing treatment so that the boys could return to a more normal home life. The lay people's sole allegiance was not to VBC, but they had enough allegiance to VBC not to be destructive; they weren't in a position to take over.

"Monumental changes" were needed at Valleyview. It suffered from inadequately trained staff and there was no provission for in-service training. It had no social services professional to coordinate the staff. Those staff who had been to college were overtrained, zealous, and inexperienced. They had "collegiate" ideas on the appropriateness of the use of marijuana, etc. Person #7 said that around August, 1972, the director tried to use a psychologist to coordinate and organize treatment. The psychologist "tried to be too theoretical," as did the younger staff. Any treatment approach proposed by the psychologist would have been subverted by the staff according to their many differing perceptual sets.

From Person #7's viewpoint, the former director's administrative problems prevented him from being an operational manager. He felt that the former director had first to deal with administration matters, especially financial matters, and was quite successful in that. When he began, VBC was receiving $415 per month per child. During his tenure it was raised to $550 and finally to $778 just before he left. By the time he left, VBC was finally in a position to balance outgo with income.

Person #7 felt that the consultant gave people an experience of change. He mollified the staff's precipitous urge to change, gave change a framework. They (the staff) learned about organizing more effective meetings, about the possibility of setting up goal-related treatment programs. But "people were racing their motors too much to take advantage of most of the suggestions."

If the consultants had used a more structured approach in reorganizing the staff, instead of using the looser approach of the negotiating sessions, the result could have been better.

The man who during the negotiations volunteered for the job of assistant director thought he was to be the assistant director in charge of all matters internal to Valleyview. The director, however, thought he had made it clear that in the negotiation sessions only the treatment portion of VBC was "up for grabs."

Person #7 felt that the best thing HIRI's consultants did was to get people together in a productive, organized milieu. It gave them an experience of constructive change. The co-consultant was "even" with everyone. She was especially helpful in reinterpreting crises in less catastrophic terms.

Person #7 wished that certain concrete things had been followed through. For example, there might have been a constructive follow-up on goal setting--to get it to the point where it could perpetuate itself. It would also have been better if the negotiating sessions had been left out, or perhaps replaced by something more structured, more directive.

5. Overall Summary of Evaluation Inputs from Interviewees

There is very little remaining of the Valleyview that received consultation from HIRI. Two-thirds of the personnel and all of the roles are changed. Animosities and heartaches made it difficult to reconstruct the VBC that might have been. No one was in a position to reflect on the institution in a cool and dispassionate manner. For former staff, just to talk of their experience was to reopen old wounds. For current staff, to talk of the old VBC was to speak of a recently vanquished foe. To change metaphors, the old Valleyview was mortally ill and the consultation could not save it.

The new VBC is a demonstration of the fact that a new director, having legitimitized power, is generally in a position to effect more changes more rapidly than is a consultant, no matter what his capabilities.*

D. What Is Suggested by the Before-and-After Questionnaire Responses

By the time the post-consultation ISSQ was distributed (September-October, 1973) most of the personnel with whom we had been working at VBC were gone: They either had resigned voluntarily or were asked to resign by the new director. The new associate director asked us to send the ISSQ forms and said he would have them filled in by the current staff. Despite repeated phone calls and, in turn, promises to carry out this commitment, they did not arrive. Finally, after much prodding, it looked as if they would be forthcoming in February, 1974. Then the new associate director resigned, and there seemed no way of obtaining the questionnaires--which, even if obtained, would have had to be filled out almost entirely by new staff members who were not present during the consultation period, although they nevertheless could have provided a picture of how they rated various practices and conditions at VBC at the time they responded to the questionnaire.

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* Comment by the project director: This does not necessarily follow as a generalization. The "legitimitized power" of a director to make changes may not result in situational improvement if the changes are unwise or are not supported by those required to implement them. Even the subtle sabotage of withheld enthusiasm can vitiate (at least for a considerable time) the possible gains from strongly resisted, arbitrarily imposed change.

Because responses to the ISSQ were unavailable, no comparative BDF-ISSQ data can be provided for VBC. What can be said, however, is that in their responses in 1972 to the BDF, the staff's overall average ranking* of their institution for all 80 items on the BDF was the least favorable among the four institutions that received consultation help. The other three staffs gave their agencies average rankings of 4.419 (most favorable) to 8.317 (least favorable). Valleyview staff gave their institution a ranking of 9.831--clearly at the bottom of the scale. The staffs of the seven nonconsultation institutions ranked their agencies from 2.1 to 9.922. Only one agency among the 11--an agency in the comparison group--was ranked lower than Valleyview. This ranking suggests that VBC was indeed a troubled setting at the beginning of the consultation intervention and that the distress was clearly visible to the staff.

E. Commentary by Edward M. Glaser, PhD, Project Director, on the VBC Consulting Intervention

Aside from any staff ratings through the questionnaire method, the director at the time we invited this institution to participate in the HIRI consultation, along with some of his peer directors of other institutions in the California Association of Children's Residential Centers, all agreed that VBC was an institution in considerable trouble. In view of this they felt that it might be an especially interesting case to include in the experimental group to see if the HIRI consultation approach might be of substantial help. Recognition of serious problems by the director and his cordial response to the prospect of consultation were counted as important favorable conditions for consultation intervention.

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*The feedback interpretation given to each institution with regard to these rankings was as follows: Please keep in mind that these rankings are defined for each item independently. This means that if your institution had a rank of 1 on any item in Column Two, your staff, in responding to a question, saw its own institution most favorably on that item. On the other hand, if your institution happened to be ranked 12 with regard to a given item, the staff in your institution felt that the institution was performing least satisfactorily with regard to that item in comparison with the way in which staffs in other institutions perceived their own institutions. Intermediate ranks of 2 through 11 should, of course, be interpreted similarly.

If the criteria of efficacy of consultation were to include such things as continuity of staff; improved quality and effective integration of program; individualized treatment planning and developmental goal attainment for each child; constructive resolution of the power struggles, divisiveness and interpersonal frictions among the staff that were apparent at the beginning of the HIRI contact with Valleyview; and job satisfaction on the part of the staff...we would have to conclude that the consultation was not effective. The agency collapsed in the throes of a major upheaval subsequent to completion of the consultation.

On the other hand, if the criteria of efficacy include clearer surfacing of partially submerged, serious, chronic problems in the organization so that they could be examined and dealt with in one way or another, then perhaps the consultation was successful in that sense.

Be that as it may, HIRI's intervention with the persons who were the clients when the consultation began did not turn out well, other than perhaps unintentionally precipitating staff changes that provided opportunity for the next and hopefully healthier or more effective generation to follow in succession. It would seem useful in retrospect to attempt an analysis of why this particular consultation was unable to bring VBC to a state of good health as an organization, and *what might be learned from the experience*. But at best, this kind of post-hoc analysis can only be speculation based on inferences from the available data--inferences affected to some degree by the orientation, values and consulting style preferences of the given commentator.

As stated in the *Overview of the Consultation Intervention*, an Activity Report was prepared by the consultant after each visit and a copy was circulated for comment to each member of the HIRI-OCD research team. A copy of two such reports on VBC, the first visit (8/16/72) and the sixth visit (10/4/72) with my marginal comments thereon, may be found in the Appendix to this section on VBC, where they serve the dual purpose of illustration and as the data base for some analytical speculations by this commentator.

In the report on the first (August 16) visit, the consultants quite *logically* invited attention of key staff members to a need to address the question of VBC's mission: What was it there to do? Without such reasonably clear and agreed-upon purpose, the VBC staff efforts to design programs and operating manuals (which they were planning to do) might be premature. *Psychologically*, however, pressure by the consultants in their first visit to get explicit mission clarification might be interpreted by these key staff members as a criticism of the way VBC was operating. Perhaps *that* was premature.

It might have set a more relaxed, non-threatening climate of beginning relationship if the kickoff visit could have included (after the morning meeting with the director) a preplanned opportunity to meet with as many persons on the staff as might be available, briefly describe the HIRI-OCD project and our own hopes/goals in working with VBC, invite their questions and ask if they had any suggestions regarding what they might wish from the HIRI consultants. In effect, what would they like us to focus on that they felt might help them? Or, how can this consultation help VBC to do a still more effective job in working with the children in their care? The words in the first VBC Activity Report show recognition of this point; e.g., "... our function was to respond to their needs." The consultation behavior, however, seemed "pushy" in prematurely advocating goal clarification and the rigidities required for "contract formulation." Five consulting visits later, in the October 4, 1972, Activity Report (appended herein), Dr. Ross summarized something of his orientation, frustrations and concerns as follows:

> During this 2-hour meeting with Persons D, E, and F I tried to follow up on a number of observations previously made, to direct the attention of this group to what we had observed to be some of the salient issues and organizational problems at VBC and, most important of all, to stimulate their thinking about the difficulty we have been having in not knowing who our audience is or what our contract with the institution is at this time. The particular issues I talked about were:
>
> A. The apparent problem throughout the institution of knowing and agreeing upon how decisions are to be made.
>
> B. Some particular problems in decision making as revealed in difficulties in devising functional "treatment plans" for particular children. A treatment plan is an agreement/decision about how the staff and a child are going to proceed and should involve particular staff interventions and particular behavioral objectives. The staff we have seen so far talk about treatment plans but do not seem to understand exactly what they are or how to arrive at them.

My (Glaser's) comments and questions on the October 4 Activity Report, written at the time it came across my desk as part of our project reporting procedure, appear on the appended copy. The main reason for appending this Activity Report is to illustrate what I perceived as a key dissonance about the consultation at Valleyview--a viewpoint voiced at our team meetings, not just in this post-mortem attempt.

On the one hand, the consultant noted in his own recount of his strategy that:

> Our initial visits at the agency had already brought to our attention certain problem areas that could potentially be destructive. The first

problem was the evident alienation among department and professional groups, and the dysfunctional effects of this on the agency. Second, we observed that the director, in an attempt to correct this dysfunctional state often placed certain demands on his staff. Their lack of integration, however, made the planning and implementation of such demands impossible. The intensity of suspiciousness, reproachfulness and hostility was extraordinary: between the director and his staff (even those whom he had recently hired); between the recently hired professionals and the cottage supervisors and cottage child care staff; and between the school teachers and the social work/child care staff.

This is a perceptive, accurate and fundamental analysis, in the judgment of this commentator.

On the other hand, however, the primary focus and perhaps the major thrust of the consultation effort seemed somewhat fixated on decision-making processes at the institution, with concomitant efforts to develop structural, organizational rearrangements and agreements about where given sorts of responsibility-authority resided. Decision making or locus of control indeed were important organizational issues at Valleyview, but until and unless the primary and largely clinical problems of "alienation, suspiciousness, reproachfulness, hostility and lack of integration" that the consultant so well recorded could be faced up to by all concerned and significantly reduced if not overcome... structural changes and system rearrangements seemed (to this commentator, at least) unlikely to get at fundamentals--or at first things first. But this admittedly is a debatable issue. The point of view offered here is not that questions of technology, structure and leadership style necessarily need to be "placed on ice" until the clinical-interpersonal issues are treated. The point rather is that attention to problems of organizational structure and decision making, without surfacing, facing and dealing constructively--somehow--with the serious basic clinical problems which were identified and agreed to as reality by essentially all concerned... was (in this commentator's opinion) not likely to lead to a viable resolution of the institution's dysfunctions so long as the basic contributory causes remain unaltered. The same observation would hold with regard to the role negotiation exercise which, according to the primary consultant at VBC, "... would attempt to alleviate these conflicts by making basic changes in the organization that might remove (at least) the structural causes of them." While this exercise seemed to yield lasting constructive results at Red Rock and Lakecrest, it did not at Valleyview. That difference, in the judgment of this commentator, could be accounted for chiefly because Valleyview was not ready or "ripe" for such an exercise and would not be ready until-unless the pervasive climate of distrust, hostility and divisiveness were somehow basically changed for the better.

Related to the above observation, during the second of my (HIRI project director's) two personal visits to Valleyview (my first visit was on January 28, 1973, accompanying the goal-planning consultant; the second visit was on May 14, 1973; I had met the director two or three times before in his visits to the HIRI office and at a project meeting in Los Angeles), I talked with staff, some of the children, and completely toured the premises, cottages and grounds, in the company of the director and two other staff members. In this tour, I noticed that the faucets were missing from three of the four sinks in the boys' washroom adjacent to the mess hall; there was no toilet paper in the washroom; the floor was littered; the cottages were dirty, smelly, with broken furniture and springs popping through the upholstery; the room occupied by the child care worker in several of the cottages was an extremely disorderly mess; the spacious outdoor grounds were poorly landscaped and generally unkempt.

The point of the above observation is not to report on poor housekeeping per se. The boys at VBC were sent there mainly by agencies of the court. A number of them were classified as delinquent or predelinquent or emotionally or behaviorally disturbed. If the institution is to be rehabilitative, what sort of role model is demonstrated by this acceptance of extreme slovenly disorder--and sometimes personal display of it--by the adult staff, and particularly by the child care worker in the cottage, who is the person closest to the children in that cottage for the longest period of time? What does this kind of practical, observable set of problems offer as something tangible for the entire VBC staff to confront? Further, the residents at Valleyview were between 11 and 15. Many of the "graduates" soon would need to try to earn a living. What about the wasted opportunities for prevocational and marketable skill training that could be inherent in teaching and requiring the children to help maintain their residence in good repair?

One might wonder whether, at an appropriate time, these kinds of obvious practical problems might have been used as a tangible vehicle for getting the entire staff to start looking at their operation of the institution; views on the underlying reasons therefor; their role-model postures; their neglected opportunities to help the children develop certain kinds of individual and group responsibilities plus, perhaps, some subsequently marketable vocational skills which could be acquired in the normal process of caring for their environment; their decision-making processes regarding who is responsible for what; and their goal-attainment planning (or lack thereof) for each child.

Incidentally, when I privately asked the director, following the tour, whether the housekeeping and maintenance needs of the institution might provide a normal opportunity for teaching certain forms of responsibility and skills, he was well aware of these problems, embarrassed by what we had seen, and angrily asserted that other persons on the staff just were not carrying out their duties or responding constructively to his oft-repeated directives concerning improved housekeeping. This prompted a subsequent critical memo from him to the staff on the subject of institutional maintenance-orderliness-cleanliness, which in turn added that much to the tensions already existing between the director and his staff. However, that memo could have afforded one more concrete example for raising the open question regarding what might be some possibly better or more effective ways to get the staff to agree about legitimate problems and then undertake responsible problem solving without a fruitless tug of war.

To cite an example of the kind of practical problem the consultants did focus on compared with the type of problem noted in this critique that was not addressed by them, the following paragraphs are taken from the November 1, 1972, Activity Report of the HIRI consultation at VBC:

> ...the group had a discussion about the previous day's meeting and specifically about how bedspreads and drapes were to be purchased. A number of alternative ways of proceeding were discussed. There were constraints in terms of the amount of money available and the necessity to expend the funds before the end of the year. On the other hand, everyone recognized the desirability of permitting as much latitude as possible in expressing personal tastes with the purpose of making the cottages more homelike. Jean suggested that it might be very important to inform the cottages about the constraints so that they would not be set up to submit requests that were unrealistic and that would have to be denied. Another issue was whether the kids would be involved in the choice.
>
> We suggested that the way in which the issue was handled could express something very profound about what the institution was there to do. For example, if the child care workers decided without consulting the children that would imply a different mission than if the children were consulted. Furthermore, focusing on buying the bedspreads and drapes might imply a different mission than if equal importance were to be placed on the way in which the children participated. In the latter instance, the institution would be saying that teaching the children to compromise, negotiate and come to a decision together was at least as important as making the purchase.

The material up to the last sentence in the first paragraph above has been cited by the HIRI consultant to VBC as one illustration of their (allegedly needed) attention to decision-making processes at the agency and to opportunities to help the children develop certain kinds of individual and group responsibilities.

The second paragraph would illustrate consulting attention to the kinds of role-model postures presented by the way the staff behaved or operated in the course of their everyday problem solving. Whether the manner in which the purchase of bedspreads was decided "could express something very profound about what the insitution was there to do" represents a sharp difference of opinion between the consultant and this commentator about what was relatively peripheral and what was central among Valleyview's problems and needs.

The observation submitted in this particular case is that attention to a matter such as how bedspreads and drapes were to be purchased was a practical but nevertheless relatively minor problem that the consultants used as grist for the mill in trying to get the staff to examine their behavior in relation to fundamental questions. That sort of problem does not seem to have anywhere near the potential for impact and import that might have been achieved if the staff had been asked somewhat early in the consulting relationship (but not at the beginning) whether they would like to examine the fact and implications of: (1) the child care worker in charge of a cottage keeping his own sleeping quarters in chaotic and dirty condition; (2) his being permitted to do so; or (3) the manifest state of disrepair of the buildings, grounds and furnishings, which in turn afford opportunities for certain kinds of responsibility training and repair-maintenance skill acquisition. From review of obvious practical problems of this sort, it might well be possible to introduce into the discussion basic issues related to the operation of the institution. On the other hand, the consultant's view in disagreement with this observation should be stated, namely:

> Jean and I would not have made that intervention because we knew that the director...was very sensitive about the physical condition of the plant. Its disrepair and dirtiness had been the subject of many reproaches and lectures that he had given the staff--all without any effect. It seemed obvious to us that the poor condition of the physical plant was an expression of the staff's hostility to the director. We understood that dealing directly with that issue early in the consultation was likely to inflame the bad feeling between the director and the staff and was likely not to lead to any constructive result--until the relationship between the director and the staff had improved enough for them to be willing to do something constructive. Improving that relationship was a major focus for the consultation.

Improving the relationships between the director and staff, and between staff departments and staff members, indeed seemed the major focus for the consultation. How to bring about increased respect and trust was the $64,000 question. The Activity Reports written after each visit often contained very sensitive observations and sometimes brilliant conceptual analyses of what had been observed. In view of the outcomes at VBC, the point of this critique is to try to figure out, as the stage magician might phrase it, why the "trick didn't work out quite as intended in this case."

Viktor Frankl* offers what may be some relevant insights here: "Man must accomplish concrete, personal tasks and fulfill concrete, personal demands... I consider it misleading to speak of 'self-fulfillment' and 'self-realization.' For what is demanded of man is not primarily fulfillment of himself, but the actualization of specific tasks in the world--and only to the degree to which he accomplishes this actualization will he also fulfill himself.... He (man) is searching for a concrete--more than that, a unique--task, the uniqueness of which corresponds to the uniqueness both of his personality and of each situation." The beginning of the consultation at VBC may have been insufficiently concrete to enable each staff member to identify with specific tasks that fit his or her personality and perception of the situation in relation to making VBC more effective for its purpose of existence, and at the same time more satisfying as a place in which to invest one's worklife. It further may be that the consultation at Valleyview failed to sense accurately and to keep measured pace with the learning readiness of that staff in that situation.

What was done in the main by the consultants seems relevant and constructive in intent. The questions raised here in an effort to learn from the experience (and not to criticize the consultation for the sake of criticism) are devoted more to "what else" or "in what other order" or "how better" to insure understanding, acceptance and commitment from all concerned for a joint venture in terms of their personalities, their perception of their situational realities and thus, their readiness for participation in problem identification and problem solving.

As the consultants stated in the material heretofore cited, the most important (and difficult) problem needing repair at VBC was the divisiveness between the director and the staff, and between various staff groups. As already expressed, it seems (to this commentator) doubtful, however, that such dysfunctional feelings could be resolved by structural changes. The latter might be more relevant and enduring if the distrust and hostility existing at VBC could significantly be reduced first in other ways. In this type of consulting situation, where the arrangement to enter into a relationship with the organization is made with the organization's chief executive officer, usually the most productive place for the consultant to invest time, after his role at the institution has been made clear to all concerned and he has surveyed "what's cooking," is with the director and his functioning in his role. In this particular situation, however, where there was so much tension between the director and at least important segments of his staff, such private consultation with the director might well be interpreted by the "opposition" as "plotting with him against them." Whether it might have been possible for any consultant in this situation to integrate the purposes of the director with the ostensible or alleged motivations of the Advisory

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*V. Frankl, Man's Search for Meaning. Beacon Press, 1959.

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Committee, so that common objectives may have developed, is an interesting and open question.

A 3-day meeting of the entire staff--just a few weeks after the HIRI relationship with VBC began--presented a fortuitous opportunity for the consultants to help the VBC director and staff identify, "work through," and agree on plans for a New Start at VBC. As reported by the HIRI consultants, they made a number of important suggestions, such as:

> The unified school district teachers wanted to take advantage of these meetings to present their plans for a new educational program involving open classrooms and educational contracting. At the end of their planning meeting, in preparation for their presentation, we suggested that they consider combining contracting with the children for educational goals with contracting for behavioral goals. In that case, the contracting team would involve a child, a representative of his cottage staff, one of his teachers and a representative of the professional staff. The plan not only would have the merit of involving the child in his own treatment plan and in introducing the notion that the educational and treatment components were part of a unified effort, but it would bring together in a working relationship the cottage and school staff for whom the organization had not previously provided a vehicle for shared effort.
>
> Even though this suggestion generally was well received by the professional, cottage and school staffs, and a consensus developed to implement it, the meetings came to an end without anyone taking responsibility for its implementation. We discussed this absence of follow-through with the staff, but they did not actively take steps to put the program into effect.
>
> During subsequent visits, after the earlier agency planning meeting, we observed many occasions in which the staff appeared preoccupied with responding to crises and did not plan the implementation of the decisions they made. We discussed this pattern with the staff whenever it seemed appropriate.

When introducing an idea that is outside the apperceptive mass of a group, and for which there is not likely to be what might be termed "fertile receptivity," it generally is better for consultants not to introduce the idea as a suggestion, but rather as a question for deliberate critique and analysis of pros, cons, risks. If, after such critique/analysis, there seems to be a consensus that it is worth trying, questions of implementation, responsibility for follow-through, etc., become more natural and situationally required. In that sequence a consultant might ask the group what they would think of drawing up a PERT-type chart for each idea they agreed was worth a trial, perhaps along a planning format such as:

The consultant noted that "most of the time and energies (of the senior staff) appeared to be taken up with the many crises in the institution, mostly at the child care level, which typically were referred to them for solution." If some of these "crises" were institution-wide, that is--of concern to all segments of the institution--it would seem that such crises might have provided the consultants with some good opportunities to help the senior staff get together, address them, and think about appropriate (and possibly new) ways of dealing with such matters at VBC. Sometimes the introduction of an emergency or common threat (a "Pearl Harbor" of sorts) which almost all members of segments of an organization can recognize as a real and present danger, can become a vehicle for integrated group responsiveness. In the process of such a coordinated response, new and improved working relationships may be evolved.

Perhaps another possibly relevant observation in this effort to analyze why the consultation at VBC did not work out successfully in terms of bringing about "good health" to that institution is the sentence from Dr. Wilhelmy's report on his interview with Persons #5 and #6 in which they offered the following perception: "They felt that the children's needs weren't put foremost at Valleyview nor were they put foremost by HIRI's consultant, and that the consultant's efforts were designed mainly to deal with staff problems."

Staff competencies in some cases may have been another matter that added significantly to VBC problems. Whether any kind of consultation approach could have remedied this total unhealthy situation is an open question.

The approach of this commentator fairly early in the consultation, but of course not immediately, would have been (if the director was willing) to raise this attitudinal issue of hostility-divisiveness-lack of mutual trust with the entire VBC staff. In the discussion there would be an open recommendation by the consultant that either they "work through" these feelings and attitudes and arrive at a consensually agreed-upon modus operandi for effective goal attainment, in terms of the institution's mission, or that, within the limits of his authority the director restaff to the degree necessary with a cast of characters who could work with him (and vice versa). Such a confrontation might have provided the kind of "crisis" that conceivably could have gotten VBC out of its rut--the rut of seemingly intractable, debilitating conflict of a house divided against itself which cannot stand. The consultant, if invited to remain rather than to leave after such a frank expression of opinion, would then be available to help in ways and means of planing, organizing, staffing, coordinating, interacting and controlling to achieve the agreed-upon common objective. Otherwise, the consultation time would be withdrawn and offered to an institution that seemed in a better position to utilize it profitably. The reason for this approach stems from the viewpoint that structural changes alone in this kind of situation probably would not prove effective for any appreciable length of time unless the destructive attitudinal problems could be basically improved.

APPENDIX

ACTIVITY REPORT - VALLEYVIEW BOYS CENTER #1

Harvey Ross August 16, 1972

Jean Hall and I spent one day at VBC, our initial visit.

The morning and lunch time were spent with A, an executive, and B, a business consultant (Systems Analysis and Design is his specialty) and a very old friend of A's.

Our agenda: to come to understand how the institution was working and to get A to talk about its problems, its successes, and to help him focus on the nature of the problems. On this first visit, also, we wanted to establish a "contract" involving our relationship with the institution and its staff.

According to A and B (who is quite familiar with the institution and who, apparently, has been trying to help A improve its operations) a basic difficulty has been that individuals through VBC have been operating and dealing with the children according to their own "philosophies" which (for example) range from behavior modification and reality therapy to a "soul wrestling" way of dealing with kids. By that, B was referring to the approach of an evangelically oriented school teacher who had involved misbehaving children in highly emotional conversations ending with expressions of their cheerful remorse, his forgiveness of them and their determination to march on into the future together. It was apparent that the different "philosophy" led to a lack of consistent treatment of children (there being numerous double messages involved) and considerable tension between staff since they did not understand that other staff members actually had entirely different points of view about children. (For example, some staff members who tended to discipline children and put pressure on them would think others, who were more passive and indulgent were goofing off.)

Solutions being worked toward by A and B were to provide a system for improving communications between staff members so that all would know what the others were doing with the children (for example, so that cottage staff would know what was happening between teachers and the children and visa versa) and the writing of procedural manuals to promote consistent operating methods (I believe, primarily regarding housekeeping and administrative procedures) among all staff members.

After lunch, we attended an administrative staff meeting (which was mostly about superficial rules and housekeeping problems) and then met with two of the participants--D, MSW and a group living program member. To our great surprise we discovered that these two are part of a group of three (including, also, one of the psychologists) who are a nucleus of eager, aggressive leaders who are determined to improve the organization by promoting more coordinated action, consistency and order--all to overcome the chaotic situation which they have been working in. (I believe that all three are relatively new, having come into VBC since the beginning of the year) They want to establish order in order that they can stop operating on a firefighting basis, do better planning and reduce the terrible burden on supervising staff members who are always responding to crises and are never on top of events. They see planning, reorganization (which they have just completed--see chart), the creation of procedural manuals as the elements out of which they will bring about order. The sign of the burden on staff supervisors has been the very rapid turnover among them--they have been unable to deal with the demands and the pressures.

They find themselves building a team--starting with the three of them to distribute the responsibility (and take it partly off the shoulders of the supervising social worker), to add better quality staff to fill vacancies, to introduce a new layer of supervision to take some responsibility for daily operation and to upgrade cottage staff in general. Seeing and hearing about the new staff members--who appear to be better prepared and better educated, though young and inexperienced suggest a considerable improvement in this regard since last January when A complained at length about the low-quality staff he had to work with.

The team (of three) has been trying to build an internal consensus for making and supporting some of the above constructive changes by having meetings of the entire staff. There was a three day meeting in June involving all of the social work staff--primarily those people on the accompanying chart--and there is another meeting planned for September which will, in addition, involve the teaching staff (for the first time) in order to promote a better relationship in coordination between the teachers and treatment personnel. (Apparently it has not yet occurred to them that everyone might be considered "treatment" staff and "teaching" staff.)

Our meeting with D and E lasted about an hour and a half. We made the following responses:

1. We pointed out that we had not heard any coherent, agreed upon statement of the purpose of VBC. (We had told the same thing to A and B.) We suggested that answering the question "Why does the institution exist--what does it accomplish?" would provide a unified sense of mission and a basis for program design and organizational structure.

   While they had been making decisions about what population they wanted to accept (boys who were two years retarded in school between the ages of 11 and 16, primarily with emotional problems who were not seriously psychotic or delinquent) this was not a statement of goal. What no one had yet considered very actively was what they wanted to do for these kids. What the output of the institution was supposed to be. (They also had not considered the strong possibility that the different "philosophies" of individuals in the institution implied different goals. We had suggested all of these same things to A and B when we had spoken with them in the morning). We recommended that a first step might be for the institution to decide what it was there to do. (In particular, we strongly recommended checking *their* decisions about what populations they wanted to deal with against the policies and expectations of policies of their referring agencies. If they did not do so, they might be making decisions about what population they wanted only to find a year or two from now that they had designed an institution and a program for children whom referring agencies were no longer referring to institutions.)

2. We suggested that designing programs and operating manuals might be premature at this stage because they had not yet decided what the institution was supposed to do--but might be necessary on an interim basis to bring order into what they apparently felt was a chaotic situation.

3. We stated that we could not decide what VBC's mission or programs *should* be but, over the *long-term* we might be able to help the organization develop an effectiveness in making those kinds of decisions for itself. We suggested we might be able to help the organization build into its fabric the ability to examine and reexamine its own mission, its programs and how it was doing in relation to the aims of its programs. Building in that kind of capability would also create organizational flexibility in meeting what would very likely be the changing demands of referring agencies. Given the rising costs of placement at institutions (now $700 per month at VBC of which $570 is paid by counties) we agreed that we could all expect county governments to be very skeptical about the need for institutions and to raise very penetrating questions in the near future. An institution which has flexibility and can think about itself and its programs critically and realistically might (if it is true) be able to identify an institutional mission which is unique--i.e., particular goals (and the programs which those goals imply) which cannot be achieved outside the institution. In the fairly near future, VBC may have to clarify that kind of mission if it is to stay in business and perform a useful function.

4. Over the *short-term* we proposed that we try to come to a better understanding of the needs of the institution, what VBC might want from us, how we might be able to help them -- all with a mind to move toward the long-term goals outlined in three. In order to proceed into identified goals for our consultation, we would have to come to know and understand a great deal more about VBC. So, over the short-term, we would want to develop an understanding of the institution, develop a picture of what we might be able to do for them and what they might want us to do.

   We began to formulate a contract: that our function was to respond to their needs. That in the beginning, especially, we would decide each week how we can plan the next week to move toward that aim.

That we will be available to everyone in the institution--not just the social work and cottage "service"--but also the school, housekeeping staff, children, and the director. If they decide it is wise politically, they might facilitate our contacts with those various constituencies in the institution.

Next week we decided to spend two days with them (at least HR will) to meet with staff individually and in groups--primarily to reduce the suspiciousness that the staff is likely to feel toward us. We felt that it would be an outstanding opportunity to come to understand what is going on in the institution if we could be present at Big Bear during their three day meeting. Thus, we want to desensitize the staff to us so that we will be welcome and accepted at the meeting. In addition, we will become more familiar with VBC and build our own data base.

In the presence of D we discussed our meeting with them, our contract and our plans for the coming week or two with A. We wanted to signal both of them that regardless of the situation between them we intend to operate as openly as possible so as not to become perceived in the context of the political problems and stresses and strains within the institution.

Beautiful report!

ACTIVITY REPORT # 6 - VALLEYVIEW BOYS CENTER

Harvey Ross October 4, 1972

I. Initial and Job Titles of Persons Seen

F	Consulting Psychologist	
D	MSW	
E	Group Living Program Coordinator	
G	Child Care Worker (CCW)	
H	"	"
I	"	"
J	Cottage #1	
K	Senior Child Care Worker, Cottage #2	
L	Social Work Associate (SWA), Cottage #2	
M	Child Care Worker (CCW), Cottage #3	
N	"	"
O	"	"
P	"	"

II. Activity Description

1. Meeting with D, E and F--initiated by them--9 to 11 a.m.

2. Meeting with G, H, I, F and E. Cottage staff development meeting--invited by E and F.

3. At 1 p.m., meeting with #2 Cottage staff, including CCWs K, L, and F. Cottage staff meeting to discuss difficult boy--invited by F.

4. Staff development meeting, #3 Cottage--for Child Care Workers--invited by D.

III. Information Gathered

1. During this 2-hour meeting with D, E and F, I tried to follow up on a number of observations previously made, to direct the attention of this group to what we had observed to be some of the salient issues and organizational problems at VBC and, most important of all, to stimulate their thinking about the difficulty *①— we have been having in not knowing who our audience is or what our contract with the institution is at this time. The particular issues I talked about were:

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* Numerals in the margins refer to EG's comments, page 6 of this Activity Report.

A. The apparent problem throughout the institution of knowing and agreeing upon how decisions are to be made.

B. ② Some particular problems in decision-making as revealed in difficulties in devising functional "treatment plans" for particular children. A treatment plan is an agreement/ decision about how the staff and a child are going to proceed and should involve particular staff interventions and particular behavioral objectives. The staff we have seen so far talk about treatment plans but do not seem to understand exactly what they are or how to arrive at them.

C. ③ The SWAs appear to be in an anomalous position--neither part of the administrative staff nor part of the cottage staff --which undermines their credibility at the school, in the cottage and with the administrative staff.

D. ④ I made some observations about some difficulties we have observed groups having running meetings. Meetings often seem to be run as if there is an agenda that identifies the subject matter for discussion, but no understanding or agreement that certain kinds of decisions are expected at the end of the meeting. We have some questions about whether supervisory staff members know how to run meetings.

E. ⑤ Our difficulty in knowing whom to address ourselves to regarding different kinds of issues appears to be a reflection of organizational indecision about where the responsibility for making those different kinds of decisions lies.

I started by doing a lot of the talking, since I felt I was carrying the ball as far as problem-clarification and identification was concerned. I was fishing to see where their concerns were and if they agreed about the nature of some of the problems I raised. If they did agree, perhaps they would become interested in identifying or creating an audience that would be "officially" recognized as responsible for considering the information we have to offer and deciding if and how to proceed to respond to that information.

Soon, all three were deeply involved in a discussion about some of the issues. It was obvious that F was very agitated because she had been running into the same problem with cottage staff being able to make decisions and plan that I had identified. I suggested that her anger and frustration might be due not so much to cottage staffs being unwilling to make and implement the plans she felt were necessary, but to their not knowing how to do that kind of planning. F agreed that perhaps they needed to be trained to make those kinds of decisions--i.e., treatment plans--and might need technical assistance in doing so. I said that if they and cottage groups (and other groups) would agree that they needed such training, we at HIRI might be able to identify institutions at which such planning seemed particularly effective and expeditious--and arrange for VBC staff to make visits to those institutions for such training. The group seemed very interested in this suggestion.

The triumvirate proposed that the Advisory Committee would constitute the appropriate audience for the kinds of issues I had raised. A first meeting had been planned for that morning, but since A was out of town and C was ill, the meeting had been canceled. However, a meeting would be held the following week. I responded that I wanted to propose a contract to the Advisory Committee: that if Jean and I made a written presentation summarizing our observation about some issues/problems/opportunities at VBC, the Advisory group would agree to respond point by point to our list--by stating that they did not agree; or that they agreed ⑥ but wished not to take any action; or that they wanted to take action (or delegate the responsibility for taking action) and would proceed to do so alone; or that they wanted to take action and would like our assistance in doing so. I pointed out that the Advisory Committee itself probably would not be the appropriate action/ planning group for a number of the issues raised, since they were not the group who either had the information or the line responsibility in those matters. However, the Advisory Committee could identify or create groups which would be appropriate.

The #2 Cottage meeting became a discussion of Charles, a 14-year-old boy who presents particular problems to the cottage staff and whom they want transferred at least out of the cottage if not out of the institution. Their attitude is more or less summarized by the following remark by one of them: "If he isn't making it in school and not making it in the cottage, he doesn't belong here. He's just screwing up the works." Apparently the cottage staff's perception of their job is to keep things running smoothly in the ⑦ cottage. While working with kids is perceived as part of that job, if a child does not respond they have to get rid of him because he is making it impossible for them to do their job, i.e., keeping things running smoothly.

Once more, the CCW's frustration with this child who was "ruining" their work performance was vented at their supervisors and the triumvirate. They wanted the CCWs to keep a child who was making life difficult for them. They appeared to feel, on the one hand, that they were being asked to run a tight ship and sail it on smooth waters, and on the other hand were being given a child who persisted in sabotaging their efforts. From their point of view, they were trying to be the good guys by trying to do a good job (in terms of their conception of that job) while their supervisors and the triumvirate were the bad guys whose behavior they could explain only as due to a (venal) policy of keeping population high for financial reasons.

3. This meeting was a continuation of the last one--adding their supervisor (K) and his supervisor (L). L ran the meeting, and again Charles was discussed. An apparently circular discussion of the problem of Charles ensued. It seemed hard for them to come to an agreement (I believe) because they had not recognized that the CCWs and supervisory staff had quite different perceptions of what the institution was there to do and, specifically, what the CCWs were there to do. Supervisory and triumvirate staff appeared not to be holding CCWs accountable for running a smooth operation. They appeared, at least verbally, to accept the disruptive influence of Charles in the cottage because they interpreted the job of the CCWs as working with particular children within the frame of reference of that child--not simply working with the child in order to get him to fit into the context of the cottage so that everything ran smoothly.

4. During this staff development meeting (of the #3 Cottage), D explained our presence to the CCWs whom we had not previously met. I asked him to do so, rather than doing so myself, because I wanted to get some idea of how he perceived us at this time. It seemed quite clear from his presentation that we have a good deal of credibility with him. A number of times during the discussion (about other issues) and after this meeting, I felt a genuine turning to me for discussion and clarification of problems with which he is concerned. The time certainly is ripe for our making a contract with this staff.

IV. Interpretation and Analyses

1. Part of the problem with running productive meetings in a child-care institution--when, because of the nature of the business, goals of different staff members may be different without their knowing it--may be that in meetings staff members are addressing themselves to different questions without knowing it. For example, in the #2 meetings, the question before the CCW group was, "we want the group to decide to get rid of Charles," while the question before

supervisory staff was, "how can we use what we are learning about him to help him develop?" (or something like that). While these different groups of staff members appeared to be talking about the same thing, they seemed to have different things in mind. The effectiveness of a staff in meetings may be related to their ability to identify and enunciate the questions to which they want to address themselves so that the group can make a decision about which questions will be addressed in a given meeting. This may enable the kind of circular discussion which never quite seems to get to the point to be avoided. This may be easier said than done.

2. Greater clarity and agreement about (or at least consciousness of differences of opinion about) institutional mission may also help focus staff discussion during meetings.

V. Plans and Objectives for Next Visit

1. To encourage the Advisory Committee to take over the function of monitoring the problem identification and problem-solving/decision-making process in the institution. I would like to encourage them to start with the written material that Jean and I will prepare if they want to go in that direction. If they accept this task (as described above), they can also decide what they might want us to do to help them. It has been one thing for us to carry the ball during the period in which we have (essentially) been gathering information, trying to come to some understanding of the institution, floating trial balloons to test institutional responsiveness and readiness to address problems, and another thing for us to try to decide for them what problems they should want to solve. We can't help them unless they claim ownership of their own problems and ask us for help.

   Whether or not Jean and I proceed to write this document will depend upon their response.

EG's Comments:

(1) In your Activity Report #1 (8/16), you say: "We began to formulate a contract." Wouldn't it have been possible to have worked this out with the director and his staff during the second and third visits, then have the director and you issue a joint memo of understanding, inviting any further questions?

(2) Would it be fair to wonder whether your putting decision-making as the key problem may be a reflection of your own involvement with this matter? If another well-trained person were observing VBC, might he just as pertinently rank lack of clarity and lack of agreement about rehabilitation objectives for the kids, lack of creative involvement of staff with kids, and lack of trust among staff members and staff segments, as the central problems?

(3) Has this problem been brought into the open for resolution?

(4) Can't there be information-exchange meetings with no decision required?

(5) What would happen if you listed the issues on which you feel a need or desirability for decision, and presented and discussed that list with the executive officers.

(6) Good! What was their response to your proposal? You don't provide "closure" here.

(7) Have you asked them what they perceive their job--and VBC's job--to be? That might make for a good and conceivably useful discussion.

IV. The Baseline Data Form (BDF) and the Institutional Self-Study Questionnaire (ISSQ)

The Development and Use of the BDF and the ISSQ in the Course of this Project

The procedure used in developing the BDF was to review various material in the available literature bearing on characteristics of an effective child care institution. For example, there is a section in Martin Gula's booklet Child-Caring Institutions, Children's Bureau Publication No. 368, 1958 (reprinted 1966),* entitled "Twenty marks of a good institution." We adapted practically all of his 20 observations because they seemed as valid in 1971-72 as in 1958. We reviewed all of the questionnaires, schedules, and membership requirement forms issued by the Child Welfare League of America for item suggestions, as well as numerous books and pamphlets and "fact sheets" (e.g., The Rater's Fact Sheet, and the Survey of Child Caring Institutions in the State of Georgia, designed by George Thomas and project staff of the Regional Institute of Social Welfare Research, University of Georgia, published in February, 1972).

Then, in our site visits to child care institutions and in discussion with consultants such as Drs. Harold Boverman and Bernice Eiduson, we solicited thinking about the important characteristics or types of practices that would be considered desirable, and with reference to which institutions might be rated "more effective" or "less effective." From an accumulated list of items which we tried in some pilot situations and exposed to invited critique, we reduced the item pool to 80 that seemed to bear upon the most important characteristics and practices.

These 80 items became the Baseline Data Form (BDF) which was administered in 1972 to the staffs of 11 institutions--the four in the experimental group and the seven in the comparison group. Statistical analysis of these data, plus further editorial analysis for possible ambiguities in the phrasing of certain items, plus new important items that came to our attention after publication of the BDF, led to our development of a revision of the BDF which then was entitled Institution Self-Study Questionnaire (ISSQ). This instrument was administered to the staffs of the 11 institutions which took the BDF a year earlier. Again, on the basis of statistical and editorial analysis further refinements were made in certain items, resulting in the present edition of the ISSQ. This instrument also contains 80 items total, 40 of which are identical or very close to the content and phraseology of those items in the BDF, while the other 40 are new or replacement items.

Some Overall Findings from the BDF-ISSQ Data

As stated above, the BDF was administered to the staffs of the four experimental and the seven comparison institutions in August-September, 1972, at the beginning of consultation. Upon completion of the consulting interventions, the ISSQ was administered to staff members at three of the four experimental institutions and at the seven comparison institutions, in the fall of 1973. It was not possible to obtain ISSQ data from the staff at Valleyview Boys Center because of the resignation of the associate director and the considerable turnover in personnel that had occurred (discussed in the section on Valleyview). Therefore, no comparative data are available for this institution.

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*Obtainable from the U.S. Government Printing Office, Washington, D.C.

Now to discuss some overall findings from the BDF-ISSQ data: Table 6 compares the individual and mean scores on the BDF-ISSQ for three of the four institutions that received consultation, with scores for the seven institutions in the comparison group which did not receive consultation.

On the 40 items which are comparable between BDF-ISSQ, the mean for the consultation institutions rose slightly (from 3.19 to 3.26), while the mean for the comparison institutions fell slightly (from 3.30 to 3.25). From these data there is no reason to infer that the intervention experience had any impact on the response to the 40 items used in the intervention settings.

If we compare the overall mean scores for 80 items (even though 40 of them were not the same in the two tests, but every item in both tests bears upon an important practice at a child care institution), the consultation group rose from 3.15 on the BDF to 3.42 on the ISSQ, while the comparison group dropped from 3.31 on the BDF to 3.24 on the ISSQ.

The material below provides more specific breakdowns of the test data. (The current edition of the ISSQ, which represents a revision and refinement of the form used in this study, is provided in Appendix B.)

The responsible test developer is professionally obligated to report relevant norms for newly constructed tests or survey instruments. Such information should treat, among other things, the response to the test of various groups of individuals, especially those groups which are most likely to be involved in future applications of the test. The following discussion is addressed principally then to child care workers and agency directors, who might be considering the ISSQ as a device for tapping agency staff opinion in the hope of developing one relevant measure of the adequacy of their ongoing agency program.

The use of any survey instrument is obviously made more economical, particularly in large agencies, if information is obtained from a sample of staff rather than from the total staff. One familiar sampling technique is to draw a random sample. Another common technique is to stratify the population available on two or more relevant variables. Stratification tends to highlight or give more precise weight to the segments of opinion found in various elements of an agency's staff. In this connection, as well as in many others, (comparing ISSQ data across various working units within a child care residential setting, or across two or more agencies) it should be evident that a reliable estimate of different groups' response tendencies to the ISSQ would be materially useful.

Table 6

	Institution	Mean Score for 40 Identical or Similar Items		Average Total Score	
		BDF 1972	ISSQ 1973	BDF 1972	ISSQ 1973
Consultation Group	1. Lakecrest	3.51	3.63	276.65	281.27
	2. Red Rock	3.04	3.15	240.90	251.86
	3. Southside	3.03	3.00	237.29	239.49
	4. Valleyview	*ND	*ND	*ND	*ND
	Group Mean	3.19	3.26	251.61	274.21
Non-Consultation Comparison Group	5. Boys Republic	3.40	3.66	270.92	281.06
	6. Cascadia	3.69	3.37	288.85	265.45
	7. Devereux	3.22	3.13	258.46	253.79
	8. Napa	2.80	3.02	224.41	242.20
	9. Sonoma	2.95	2.43	243.84	207.78
	10. Yakima	3.22	3.29	257.56	265.66
	11. Youth Adventures	3.89	3.84	309.94	299.26
	Group Mean	3.30	3.25	264.85	259.31

*ND = No data available.

Valleyview did not administer ISSQ questionnaire. Data for BDF administration were handled differently in 1972 (Valleyview was left out of computer tables done in 1973-74), and the only comparative information we have is that Valleyview was tied for lowest ranking among the 11 institutions whose staffs filled out the BDF.

There is, of course, ample reason for assuming that different types of agency staff will be less than equally sensitive to problems and proficiencies in agency programming. For example, one would anticipate that various groups of child care staff would tend to be differentially knowledgeable and rather divergent in attitude toward such varied aspects of residential programming as food service, educational activity and medical care. Thus, the perception of the quality of agency effort may be very different for newly recruited as opposed to well seasoned staff, for daytime staff as opposed to the night shift, etc. Whatever the staff person's individual role may be it will almost certainly affect the character of the information available to him, the kind of information he absorbs and the special interpretation he places on information as he integrates it. Cochran suggests that:

> The traveler who spends ten days in a foreign country, and then proceeds to write a book telling the inhabitants how to revive their industries, reform their political system, balance their budget and improve the food in their hotels is a familiar figure of fun.

In presenting our data about the response to the ISSQ of different groups, we plan to inspect first 80 individual items of the test to identify those items which appear to elicit divergent patterns of response from various groups of child care agency staff. We will then examine the related question, how do various groups tend to respond to the total instrument? Our focus will be on three staff-related variables: sex, age and agency role of staff.

To begin, we should recall the five score values attached as answer options to each survey item. These values are:

5 = excellent
4 = good
3 = satisfactory
2 = fair
1 = poor

Using these answer weights it is possible to derive a total and an average score for any subset of individuals responding to an item. Our initial effort will therefore be to aggregate the scores for male respondents in the ten child care agencies to establish an overview first of how males (and then subsequently how female staff) responded to each of the ISSQ items. By this means of accumulating data across agencies the influence of individual agency program conditions on staffs' responses will be diluted or neutralized. We also want to recall that the 80 survey items were classified into five substantive areas or clusters: the treatment related items (1-29); the community interaction related items (30-36); evaluation procedure related items (37-43); staff development related items (44-54); and general organizational related items (55-80). We refer to these a priori item groupings or categories here because we plan to examine the influence of our three population variables, (sex, age and role) not only on each of the 80 items, but also on the combination of items included in each of these five content clusters.

A. The Item Focus

We now move to examine data for the purpose of distinguishing those items which elicited disparate responses from various subgroups of child care workers.

Analysis by sex of workers: Table 7 contains data for each of the 80 items on the ISSQ, ordered by the response of 189 males and 203 females employed in ten California residential centers for children. It should be remembered that 422 staff completed the survey in the ten agencies, so that 30 staff apparently failed to report their sex in completing the ISSQ. The data in Table 7 constitute the basic summary statistics--including the amount of missing data, the average score, the median score value and the variability, or standard deviation around the mean--cataloged independently for the two sexes. The number of males producing a scorable response to a given item is, of course, 189 minus the missing responses to that item. Similarly, for female staff the number of scorable responses to an item is 203 minus the item-associated missing responses. Our data indicate that male employees produced virtually the same rate of missing data as female staff: the amount of missing responses per item for males was 14 percent and for females, 18 percent.

We now present those items from the ISSQ on which male and female staff produced statistically different response patterns as documented in the list t-values.

Item #	t-Value	Probability
3	2.87	<.01
4	3.00	.01
5	3.03	.01
13	2.12	.05
16	2.21	.05
27	2.32	.05
36	2.25	.05
43	2.49	.05
47	2.55	.05
49	2.74	.05
50	2.38	.05
52	2.54	.05
53	2.39	.05
57	2.44	.05
58	3.42	.01
59	3.01	.01

RESPONSE IN TEN INSTITUTIONS TO ISSQ BY SEX OF STAFF

Item No.	Sex Category: Male Staff N = 189				Sex Category: Female Staff N = 203			
	Missing Data	Mean	Median	Standard Devia-tion	Missing Data	Mean	Median	Stand Devi tion
1	20	3.414	3.427	1.009	24	3.296	3.273	1.03
2	38	3.278	3.415	1.195	35	3.286	3.405	1.19
3	37	3.441	3.600	1.084	63	3.086	3.096	1.02
4	34	3.406	3.508	1.024	63	3.057	3.089	0.97
5	42	3.286	3.348	1.066	75	2.898	2.960	1.04
6	21	3.298	3.385	1.036	50	3.131	3.143	1.02
7	21	3.196	3.236	1.090	40	3.006	2.981	1.08
8	2	3.353	3.506	0.958	14	3.275	3.240	0.99
9	42	2.912	2.976	1.233	63	2.879	2.789	1.21
10	25	3.171	3.143	0.937	31	2.983	3.000	1.06
11	25	3.305	3.283	0.896	38	3.400	3.434	1.01
12	31	3.266	3.411	1.097	37	3.235	3.266	1.10
13	7	4.060	4.175	0.929	8	3.846	3.981	1.02

Table 7

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY SEX OF STAFF

Sex Category: Male Staff N = 189				Sex Category: Female Staff N = 203			
Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
20	3.414	3.427	1.009	24	3.296	3.273	1.031
38	3.278	3.415	1.195	35	3.286	3.405	1.195
37	3.441	3.600	1.084	63	3.086	3.096	1.028
34	3.406	3.508	1.024	63	3.057	3.089	0.973
42	3.286	3.348	1.066	75	2.898	2.960	1.049
21	3.298	3.385	1.036	50	3.131	3.143	1.024
21	3.196	3.236	1.090	40	3.006	2.981	1.086
2	3.353	3.506	0.958	14	3.275	3.240	0.994
42	2.912	2.976	1.233	63	2.879	2.789	1.214
25	3.171	3.143	0.937	31	2.983	3.000	1.068
25	3.305	3.283	0.896	38	3.400	3.434	1.017
31	3.266	3.411	1.097	37	3.235	3.266	1.101
7	4.060	4.175	0.929	8	3.846	3.981	1.029

Item #	t-Value	Probability
67	2.36	.05
68	2.53	.05
69	2.23	.05
70	2.00	.05
75	2.39	.05

In summary, 21 items on the ISSQ appear to elicit sex-linked response tendencies in our study results. Of the 21 items which elicit dissimilar responses from male and female staff, six are among the items classed under the treatment area, one is in the area of community interaction, one is in the item domain of evaluation procedures, five fall in the staff development category, and the final eight are found under the province of general organization.

Analysis by age of workers: In Table 8 we present data for the 80 ISSQ items partitioned according to the four age groupings employed on the face sheet of the survey form. Of the 422 staff responding across the ten agencies all but 26 provided the desired age information about themselves. The missing data experience with the four age groups ranges from 14 percent with the 20-29 age group, through 15 percent for those in both the 30-39 and 40-49 age groups to 19 percent in the 50 and over age group. There seems to be a positive relation, such that the older staff produce more missing data than younger staff. However, the disparity among the various age groups is, indeed, modest.

This brings us to the listing of items on which the four age groupings produced statistically deviant item responses as measured by the analysis of variance and the derived F-Values.

Item #	F-Value	Probability
9	2.641	<.05
10	4.493	.01
19	2.822	.05
21	2.857	.05
22	4.088	.05
24	2.812	.05
32	2.968	.05
42	4.152	.01
75*	3.830	.01

Of the nine items which were determined to exhibit response differences by age, only item 75 is starred to indicate that it also yielded sex-linked differences. Further, six of the items are found in the treatment

RESPONSE IN TEN INSTITUTIONS TO ISSQ BY AGE OF STAFF

Item No.	Age Category: 20-29 N = 136				Age Category: 30-39 N = 94				Age Category: 40-49 N = 66				
	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data .	Mean	Median	Standard Deviation	Mi D
1	13	3.382	3.333	1.028	9	3.224	3.231	0.943	8	3.207	3.265	1.072	
2	21	3.330	3.512	1.114	21	3.164	3.175	1.190	13	3.132	3.222	1.345	
3	39	3.320	3.303	1.006	22	3.056	3.125	1.086	14	3.346	3.600	1.186	
4	37	3.343	3.359	0.928	22	3.111	3.204	1.042	14	3.212	3.250	1.194	
5	41	3.189	3.229	1.055	27	3.000	3.058	1.059	19	3.170	3.250	1.185	
6	26	3.309	3.338	1.073	12	3.146	3.233	0.995	10	3.214	3.300	1.140	
7	16	3.100	3.081	1.008	14	3.025	3.100	1.125	10	2.946	2.853	1.212	
8	3	3.391	3.487	0.968	3	3.330	3.394	0.895	3	3.190	3.225	1.090	
9	38	3.082	3.152	1.137	26	2.588	2.630	1.200	18	2.771	2.500	1.356	
10	15	3.331	3.316	0.916	18	2.947	2.969	0.951	11	2.909	2.932	1.076	
11	21	3.383	3.438	0.923	14	3.287	3.219	1.009	11	3.382	3.295	1.009	
12	26	3.355	3.467	1.063	16	3.103	3.083	1.180	8	3.190	3.313	1.083	
13	6	3.954	4.098	1.007	5	3.876	4.015	1.043	1	3.815	3.981	1.088	

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY AGE OF STAFF

Table 8

20-29		Age Category: 30-39 N = 94				Age Category: 40-49 N = 66				Age Category: 50 or over N = 100			
ian	Standard Devia-tion	Missing Data	Mean	Median	Standard Devia-tion	Missing Data .	Mean	Median	Standard Devia-tion	Missing Data	Mean	Median	Standard Devia-tion
33	1.028	9	3.224	3.231	0.943	8	3.207	3.265	1.072	13	3.506	3.552	1.044
12	1.114	21	3.164	3.175	1.190	13	3.132	3.222	1.345	19	3.407	3.547	1.022
03	1.006	22	3.056	3.125	1.086	14	3.346	3.600	1.186	27	3.342	3.440	1.044
59	0.928	22	3.111	3.204	1.042	14	3.212	3.250	1.194	26	3.270	3.339	0.941
29	1.055	27	3.000	3.058	1.059	19	3.170	3.250	1.185	32	3.088	3.188	1.033
38	1.073	12	3.146	3.233	0.995	10	3.214	3.300	1.140	25	3.173	3.171	0.891
81	1.008	14	3.025	3.100	1.125	10	2.946	2.853	1.212	23	3.286	3.348	1.050
87	0.968	3	3.330	3.394	0.895	3	3.190	3.225	1.090	7	3.280	3.309	0.960
52	1.137	26	2.588	2.630	1.200	18	2.771	2.500	1.356	25	3.013	3.043	1.214
16	0.916	18	2.947	2.969	0.951	11	2.909	2.932	1.076	15	2.894	2.891	1.091
38	0.923	14	3.287	3.219	1.009	11	3.382	3.295	1.009	19	3.358	3.414	0.926
67	1.063	16	3.103	3.083	1.180	8	3.190	3.313	1.083	19	3.247	3.360	1.043
98	1.007	5	3.876	4.015	1.043	1	3.815	3 981	1.088	4	4.021	4.100	0.882

RESPONSE IN TEN INSTITUTIONS TO ISSQ BY AGE OF STAFF

Item No.	Age Category: 20-29 N = 136				Age Category: 30-39 N = 94				Age Category: 40-49 N = 66			
	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
14	8	3.297	3.344	1.053	8	3.047	3.155	1.062	6	3.133	3.136	1.065
15	6	3.238	3.227	1.048	6	3.170	3.194	1.008	4	3.065	3.111	1.054
16	10	3.341	3.425	1.013	9	3.094	3.109	0.971	6	3.200	3.200	1.117
17	9	3.646	3.755	0.980	3	3.495	3.542	0.899	8	3.483	3.617	0.941
18	5	3.664	3.777	0.974	4	3.544	3.717	0.926	6	3.267	3.350	1.103
19	7	3.457	3.446	0.976	16	3.256	3.321	1.025	16	2.980	2.929	1.152
20	9	3.441	3.633	1.096	14	3.400	3.537	1.154	8	3.138	3.100	1.235
21	9	3.496	3.490	0.942	13	3.222	3.241	0.987	9	3.070	3.000	1.067
22	13	3.333	3.400	1.150	13	3.210	3.152	1.021	9	2.807	2.800	1.060
23	13	3.130	3.098	1.000	11	3.084	3.103	0.990	10	2.911	2.940	0.996
24	11	3.288	3.317	1.038	10	3.321	3.367	1.008	9	2.860	2.925	1.060
25	29	3.327	3.371	0.969	27	3.090	3.111	1.069	23	3.116	3.182	1.238
26	24	3.286	3.357	0.905	23	3.099	3.087	1.071	22	3.136	3.143	1.173

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY AGE OF STAFF

ory: 20-29 136		Age Category: 30-39 N = 94				Age Category: 40-49 N = 66				Age Category: 50 or over N = 100			
Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
3.344	1.053	8	3.047	3.155	1.062	6	3.133	3.136	1.065	22	3.269	3.300	0.907
3.227	1.048	6	3.170	3.194	1.008	4	3.065	3.111	1.054	13	3.241	3.179	0.940
3.425	1.013	9	3.094	3.109	0.971	6	3.200	3.200	1.117	13	3.299	3.355	1.058
3.755	0.980	3	3.495	3.542	0.899	8	3.483	3.617	0.941	10	3.378	3.529	1.077
3.777	0.974	4	3.544	3.717	0.926	6	3.267	3.350	1.103	9	3.505	3.543	0.911
3.446	0.976	16	3.256	3.321	1.025	16	2.980	2.929	1.152	19	3.383	3.350	1.007
3.633	1.096	14	3.400	3.537	1.154	8	3.138	3.100	1.235	18	3.488	3.567	1.033
3.490	0.942	13	3.222	3.241	0.987	9	3.070	3.000	1.067	17	3.422	3.383	1.127
3.400	1.150	13	3.210	3.152	1.021	9	2.807	2.800	1.060	25	3.333	3.276	1.095
3.098	1.000	11	3.084	3.103	0.990	10	2.911	2.940	0.996	23	3.156	3.121	0.974
3.317	1.038	10	3.321	3.367	1.008	8	2.860	2.925	1.060	21	3.291	3.360	1.088
3.371	0.969	27	3.090	3.111	1.069	23	3.116	3.182	1.238	40	3.433	3.447	1.079
3.357	0.905	23	3.099	3.087	1.071	22	3.136	3.143	1.173	31	3.377	3.479	0.956

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY AGE OF STAFF

Item No.	Age Category: 20-29 N = 136				Age Category: 30-39 N = 94				Age Category: 40-49 N = 66			
	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
27	43	3.118	3.097	1.031	24	2.886	2.875	1.123	21	3.089	3.107	1.203
28	11	3.480	3.600	1.090	11	3.337	3.548	1.161	7	3.390	3.474	1.051
29	7	3.496	3.615	1.024	1	3.462	3.587	0.962	5	3.361	3.556	1.001
30	19	2.726	2.730	1.088	19	2.600	2.673	1.090	19	2.277	2.091	1.210
31	19	2.658	2.629	1.168	18	2.434	2.405	1.112	16	2.280	2.083	1.246
32	7	3.388	3.486	1.078	9	3.165	3.207	0.998	9	2.930	2.824	1.163
33	24	2.848	2.824	1.232	17	2.662	2.696	1.021	5	2.770	2.842	1.244
34	24	3.054	3.100	1.146	12	2.890	2.833	1.089	5	3.148	3.125	1.123
35	34	3.167	3.184	1.161	22	3.014	3.071	1.107	10	3.214	3.324	1.171
36	34	2.598	2.439	1.213	23	2.423	2.435	0.981	11	2.545	2.412	1.214
37	41	3.116	3.173	1.050	27	2.836	2.897	1.024	18	2.958	2.900	0.988
38	9	3.591	3.745	1.057	11	3.482	3.649	0.992	7	3.492	3.476	1.040
39	16	3.375	3.348	0.979	13	3.235	3.266	0.884	9	3.211	3.205	1.031

RESPONSE IN TEN INSTITUTIONS TO ISSQ BY AGE OF STAFF

ry: 20-29 36		Age Category: 30-39 N = 94				Age Category: 40-49 N = 66				Age Category: 50 or over N = 100			
ledian	Standard Devia- tion	Missing Data	Mean	Median	Standard Devia- tion	Missing Data	Mean	Median	Standard Devia- tion	Missing Data	Mean	Median	Standard Devia- tion
3.097	1.031	24	2.886	2.875	1.123	21	3.089	3.107	1.203	32	3.235	3.370	0.916
3.600	1.090	11	3.337	3.548	1.161	7	3.390	3.474	1.051	14	3.442	3.586	1.036
3.615	1.024	1	3.462	3.587	0.962	5	3.361	3.556	1.001	7	3.634	3.671	0.882
2.730	1.088	19	2.600	2.673	1.090	19	2.277	2.091	1.210	34	2.768	2.688	1.170
2.629	1.168	18	2.434	2.405	1.112	16	2.280	2.083	1.246	32	2.588	2.654	1.082
3.486	1.078	9	3.165	3.207	0.998	9	2.930	2.824	1.163	12	3.375	3.423	1.075
2.824	1.232	17	2.662	2.696	1.021	5	2.770	2.842	1.244	18	3.024	3.038	1.100
3.100	1.146	12	2.890	2.833	1.089	5	3.148	3.125	1.123	11	3.112	3.185	1.112
3.184	1.161	22	3.014	3.071	1.107	10	3.214	3.324	1.171	20	3.475	3.469	0.954
2.439	1.213	23	2.423	2.435	0.981	11	2.545	2.412	1.214	26	2.811	2.750	1.190
3.173	1.050	27	2.836	2.897	1.024	18	2.958	2.900	0.988	35	3.092	3.158	1.208
3.745	1.057	11	3.482	3.649	0.992	7	3.492	3.476	1.040	10	3.589	3.700	0.923
3.348	0.979	13	3.235	3.266	0.884	9	3.211	3.205	1.031	17	3.277	3.345	0.915

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY AGE OF STAFF

Item No.	Age Category: 20-29 N = 136				Age Category: 30-39 N = 94				Age Category: 40-49 N = 66			
	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
40	17	3.210	3.242	1.127	15	3.228	3.250	1.062	8	3.138	3.091	1.016
41	13	3.285	3.343	1.028	5	3.258	3.304	1.050	3	3.254	3.271	0.999
42	12	3.484	3.582	0.975	6	3.364	3.338	0.949	5	2.984	3.000	0.922
43	33	2.262	2.141	1.093	29	2.354	2.308	1.217	23	2.395	2.156	1.218
44	5	3.687	3.783	0.805	3	3.692	3.750	0.826	2	3.656	3.731	0.963
45	10	2.873	2.912	1.200	4	3.000	3.000	0.983	3	2.937	2.957	1.014
46	12	3.339	3.500	1.202	8	3.500	3.667	1.049	6	3.367	3.583	1.134
47	8	3.383	3.395	1.237	4	3.467	3.614	1.093	0	3.197	3.167	1.218
48	6	3.100	3.100	1.193	1	3.215	3.171	1.051	3	2.873	2.960	1.171
49	6	3.062	3.095	1.193	3	2.901	2.963	1.265	1	2.923	2.972	1.254
50	10	3.127	3.114	1.166	6	3.091	3.100	1.161	4	2.903	2.950	1.211
51	46	2.756	2.876	1.115	35	2.915	2.938	1.005	22	3.159	3.167	1.098
52	14	3.025	3.024	1.132	11	3.133	3.120	1.045	9	3.175	3.175	1.104

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY AGE OF STAFF

: 20-29		Age Category: 30-39 N = 94				Age Category: 40-49 N = 66				Age Category: 50 or over N = 100			
dian	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
242	1.127	15	3.228	3.250	1.062	8	3.138	3.091	1.016	21	3.304	3.327	1.042
343	1.028	5	3.258	3.304	1.050	3	3.254	3.271	0.999	5	3.253	3.257	0.978
582	0.975	6	3.364	3.338	0.949	5	2.984	3.000	0.922	14	3.267	3.375	0.818
41	1.093	29	2.354	2.308	1.217	23	2.395	2.156	1.218	34	2.333	2.088	1.257
783	0.805	3	3.692	3.750	0.826	2	3.656	3.731	0.963	4	3.740	3.760	0.669
12	1.200	4	3.000	3.000	0.983	3	2.937	2.957	1.014	8	3.043	3.118	1.047
00	1.202	8	3.500	3.667	1.049	6	3.367	3.583	1.134	11	3.461	3.606	1.098
95	1.237	4	3.467	3.614	1.093	0	3.197	3.167	1.218	4	3.406	3.643	1.111
00	1.193	1	3.215	3.171	1.051	3	2.873	2.960	1.171	4	3.135	3.176	1.082
95	1.193	3	2.901	2.963	1.265	1	2.923	2.972	1.254	5	2.968	3.047	1.086
14	1.166	6	3.091	3.100	1.161	4	2.903	2.950	1.211	4	3.063	3.125	1.014
76	1.115	35	2.915	2.938	1.005	22	3.159	3.167	1.098	38	3.048	3.091	1.220
24	1.132	11	3.133	3.120	1.045	9	3.175	3.175	1.104	7	3.247	3.276	1.090

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY AGE OF STAFF

Item No.	Age Category: 20-29 N = 136				Age Category: 30-39 N = 94				Age Category: 40-49 N = 66			
	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
53	10	3.206	3.198	0.990	10	3.119	3.118	0.974	7	3.153	3.225	1.080
54	8	3.031	3.000	1.143	10	2.929	2.919	0.941	5	2.885	2.925	1.082
55	33	2.903	2.850	1.151	23	2.944	2.960	1.081	13	2.849	2.906	1.099
56	45	2.945	2.922	1.177	31	2.984	3.075	1.211	18	2.958	2.929	1.320
57	40	3.208	3.203	1.085	32	3.048	3.132	1.260	17	3.143	3.133	1.275
58	44	2.772	2.727	1.241	26	2.824	2.929	1.360	21	2.778	2.583	1.412
59	42	2.862	2.848	1.258	22	3.069	3.313	1.325	21	3.000	3.063	1.508
60	13	3.691	3.956	1.307	9	3.812	3.985	1.096	10	3.893	4.233	1.246
61	11	3.456	3.487	1.111	10	3.583	3.726	1.089	10	3.250	3.500	1.210
62	18	3.314	3.389	1.043	9	3.259	3.290	0.966	7	3.458	3.609	1.088
63	15	3.248	3.351	1.113	9	3.294	3.360	1.045	7	3.254	3.421	1.139
64	12	3.081	3.065	1.079	6	2.875	2.938	1.070	5	2.836	2.911	1.128
65	8	3.148	3.175	1.184	3	3.143	3.258	1.101	5	2.885	2.882	1.212

RESPONSE IN TEN INSTITUTIONS TO ISSQ BY AGE OF STAFF

y: 20-29 36		Age Category: 30-39 N = 94				Age Category: 40-49 N = 66				Age Category: 50 or over N = 100			
edian	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
.198	0.990	10	3.119	3.118	0.974	7	3.153	3.225	1.080	16	3.179	3.292	1.043
.000	1.143	10	2.929	2.919	0.941	5	2.885	2.925	1.082	15	3.129	3.200	0.973
.850	1.151	23	2.944	2.960	1.081	13	2.849	2.906	1.099	31	3.029	3.050	1.029
.922	1.177	31	2.984	3.075	1.211	18	2.958	2.929	1.320	36	3.000	3.111	1.054
.203	1.085	32	3.048	3.132	1.260	17	3.143	3.133	1.275	40	3.367	3.450	1.119
.727	1.241	26	2.824	2.929	1.360	21	2.778	2.583	1.412	39	2.721	2.725	1.097
.848	1.258	22	3.069	3.313	1.325	21	3.000	3.063	1.508	42	3.121	3.167	1.258
.956	1.307	9	3.812	3.985	1.096	10	3.893	4.233	1.246	6	3.862	4.125	1.206
.487	1.111	10	3.583	3.726	1.089	10	3.250	3.500	1.210	15	3.400	3.480	1.026
.389	1.043	9	3.259	3.290	0.966	7	3.458	3.609	1.088	12	3.352	3.353	0.971
.351	1.113	9	3.294	3.360	1.045	7	3.254	3.421	1.139	14	3.395	3.500	0.949
.065	1.079	6	2.875	2.938	1.070	5	2.836	2.911	1.128	14	2.919	2.984	0.997
.175	1.184	3	3.143	3.258	1.101	5	2.885	2.882	1.212	10	3.267	3.380	1.110

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY AGE OF STAFF

	Age Category: 20-29 N = 136				Age Category: 30-39 N = 94				Age Category: 40-49 N = 66			
Item No.	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
66	11	3.144	3.154	1.183	7	2.908	2.968	1.158	6	2.717	2.700	1.166
67	14	3.115	3.132	1.194	3	3.088	3.074	1.226	4	2.774	2.676	1.151
68	24	2.911	2.900	1.111	18	2.803	2.857	1.096	13	2.774	2.857	1.068
69	62	3.324	3.357	1.087	45	3.429	3.417	0.979	26	3.275	3.269	0.960
70	13	3.200	3.257	1.260	14	2.975	3.065	1.201	9	2.912	3.000	1.229
71	12	3.371	3.500	1.115	10	3.452	3.667	1.102	9	3.281	3.467	1.192
72	62	3.000	3.000	1.170	45	2.918	2.917	1.096	30	3.056	3.063	1.120
73	33	3.233	3.264	1.156	19	3.200	3.348	1.263	8	3.172	3.250	1.244
74	16	3.258	3.300	1.111	10	2.964	2.964	1.103	8	2.914	2.900	1.159
75	6	2.800	2.824	1.278	1	3.011	3.000	1.147	3	3.254	3.523	1.244
76	9	3.409	3.464	0.979	6	3.443	3.406	0.981	4	3.339	3.389	1.115
77	18	3.288	3.287	1.005	9	3.141	3.162	0.953	10	2.911	2.962	1.014
78	20	3.138	3.115	1.021	12	3.110	3.149	0.994	10	2.964	2.900	1.095

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY AGE OF STAFF

20-29		Age Category: 30-39 N = 94				Age Category: 40-49 N = 66				Age Category: 50 or over N = 100			
dian	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
154	1.183	7	2.908	2.968	1.158	6	2.717	2.700	1.166	13	3.069	3.138	1.139
132	1.194	3	3.088	3.074	1.226	4	2.774	2.676	1.151	6	3.160	3.179	1.194
00	1.111	18	2.803	2.857	1.096	13	2.774	2.857	1.068	33	2.985	3.021	1.007
57	1.087	45	3.429	3.417	0.979	26	3.275	3.269	0.960	47	3.226	3.261	0.933
57	1.260	14	2.975	3.065	1.201	9	2.912	3.000	1.229	24	3.079	3.167	1.117
00	1.115	10	3.452	3.667	1.102	9	3.281	3.467	1.192	12	3.261	3.423	1.140
00	1.170	45	2.918	2.917	1.096	30	3.056	3.063	1.120	46	3.352	3.438	1.049
64	1.156	19	3.200	3.348	1.263	8	3.172	3.250	1.244	26	3.459	3.500	1.075
00	1.111	10	2.964	2.964	1.103	8	2.914	2.900	1.159	12	3.023	3.076	1.072
24	1.278	1	3.011	3.000	1.147	3	3.254	3.523	1.244	6	3.298	3.274	1.125
64	0.979	6	3.443	3.406	0.981	4	3.339	3.389	1.115	10	3.611	3.694	1.057
87	1.005	9	3.141	3.162	0.953	10	2.911	2.962	1.014	18	3.207	3.188	0.952
15	1.021	12	3.110	3.149	0.994	10	2.964	2.900	1.095	25	3.347	3.250	0.937

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY AGE OF STAFF

Item No.	Age Category: 20-29 N = 136				Age Category: 30-39 N = 94				Age Category: 40-49 N = 66				M
	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data .	Mean	Median	Standard Deviation	
79	11	3.000	3.012	1.136	8	3.000	3.083	1.168	7	2.847	2.920	1.064	
80	4	3.492	3.456	1.115	0	3.596	3.667	1.071	2	3.531	3.650	1.154	

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY AGE OF STAFF

y: 20-29 36		Age Category: 30-39 N = 94				Age Category: 40-49 N = 66				Age Category: 50 or over N = 100			
edian	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data .	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
.012	1.136	8	3.000	3.083	1.168	7	2.847	2.920	1.064	11	2.989	3.000	1.006
.456	1.115	0	3.596	3.667	1.071	2	3.531	3.650	1.154	3	3.660	3.764	1.030

frame of reference items (1-29), while one is found in each of the following: the community interaction group, the evaluative group and the general organizational group.

Analysis by position: The face sheet of the ISSQ makes provision for three types of organizational position: (1) the program/treatment staff, (2) the administrative/support staff and (3) both. The latter group incorporates dual role functions in their day-to-day agency work. Table 9 reports by item summary data for the three classes of staff position across the ten institutions. Position information is available for 383 staff members, so that 39 staff failed to provide it. The missing data performance is equivalent for program/treatment staff (17%) and administrative/support staff (18%). However, the missing data factor is clearly less pronounced in the survey response of staff who serve in a combined treatment-administrative role.

We now disclose those items on the survey form which yield statistically significant differences among the response of the three "position" classes of staff. The analysis of variance identified the following 17 items, their F-Values and associated probabilities:

Item #	F-Value	Probability
6	3.594	$<$.05
18	3.472	.05
19^{B}	3.105	.05
20	5.856	.01
22^{B}	4.147	.05
23	3.102	.05
34	4.198	.05
35	3.901	.05
36^{A}	5.784	.01
40	4.391	.05
43^{A}	7.508	.01
50^{A}	4.948	.01
55	5.287	.01
68^{A}	3.714	.05
74	4.757	.01
75^{AB}	3.064	.05
77	3.869	.05

Of the seventeen items revealing different constellations of response for staff occupying different agency roles, five items were among the class of 29 treatment-type items; three were found among the eight community interaction items; two were among the six evaluative items; one was among the group of eleven staff development items; and five were members of the general organization cluster of items. Further, with regard to overlap

RESPONSE IN TEN INSTITUTIONS TO ISSQ BY POSITION OF STAFF

Item No.	Position Category: Program Staff N = 248				Position Category: Adminis. Staff N = 83				Posit
	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data
1	32	3.324	3.322	1.064	10	3.548	3.593	0.097	0
2	51	3.259	3.361	1.156	14	3.290	3.519	1.152	6
3	67	3.182	3.238	1.128	22	3.443	3.565	1.025	12
4	67	3.204	3.275	1.079	20	3.333	3.348	0.933	11
5	76	3.047	3.103	1.149	28	3.345	3.360	0.907	14
6	45	3.217	3.257	1.073	21	3.452	3.420	0.918	7
7	38	3.076	3.045	1.121	19	3.281	3.395	1.031	5
8	6	3.285	3.333	1.029	9	3.365	3.423	0.900	2
9	67	2.961	2.940	1.204	26	2.930	2.958	1.223	9
10	37	3.019	3.013	1.042	16	3.179	3.111	0.968	1
11	42	3.330	3.353	0.977	17	3.439	3.417	0.930	5
12	47	3.214	3.295	1.104	15	3.338	3.413	1.045	5
13	9	3.925	4.080	1.042	6	3.987	4.097	0.953	1

RESPONSE IN TEN INSTITUTIONS TO ISSQ BY POSITION OF STAFF

ory: Program Staff 248		Position Category: Adminis. Staff N = 83				Position Category: Both N = 52			
Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
3.322	1.064	10	3.548	3.593	0.097	0	3.250	3.208	0.883
3.361	1.156	14	3.290	3.519	1.152	6	3.283	3.500	1.167
3.238	1.128	22	3.443	3.565	1.025	12	3.275	3.417	0.933
3.275	1.079	20	3.333	3.348	0.933	11	3.171	3.235	0.803
3.103	1.149	28	3.345	3.360	0.907	14	2.947	3.038	0.957
3.257	1.073	21	3.452	3.420	0.918	7	2.911	2.958	0.973
3.045	1.121	19	3.281	3.395	1.031	5	2.872	2.917	1.035
3.333	1.029	9	3.365	3.423	0.900	2	3.260	3.289	0.899
2.940	1.204	26	2.930	2.958	1.223	9	2.535	2.455	1.222
3.013	1.042	16	3.179	3.111	0.968	1	3.059	3.146	1.008
3.353	0.977	17	3.439	3.417	0.930	5	3.213	3.175	0.858
3.295	1.104	15	3.338	3.413	1.045	5	3.319	3.458	1.024
4.080	1.042	6	3.987	4.097	0.953	1	4.000	4.080	0.872

Table 9

BY POSITION OF STAFF

Item No.	Position Category: Program Staff N = 248				Position Category: Adminis. Staff N = 83				Posi
	Missing Data	Mean	Median	Standard Devia-tion	Missing Data	Mean	Median	Standard Devia-tion	Missing Data .
14	26	3.180	3.233	1.090	17	3.333	3.452	0.950	0
15	14	3.179	3.195	1.041	15	3.412	3.500	0.996	0
16	18	3.252	3.268	1.052	17	3.439	3.607	1.025	2
17	21	3.471	3.602	1.010	11	3.611	3.643	0.897	0
18	11	3.460	3.561	1.023	11	3.806	3.905	0.866	0
19	38	3.229	3.227	1.056	17	3.591	3.595	1.007	1
20	33	3.247	3.364	1.148	12	3.746	3.879	0.967	1
21	30	3.303	3.293	1.069	18	3.538	3.481	0.937	0
22	38	3.167	3.109	1.180	19	3.516	3.431	0.816	3
23	36	3.061	3.040	1.049	20	3.333	3.360	0.861	1
24	31	3.171	3.173	1.107	18	3.462	3.641	0.920	1
25	76	3.221	3.280	1.107	32	3.294	3.238	1.082	7
26	69	3.162	3.233	1.045	25	3.448	3.417	0.841	4

BY POSITION OF STAFF

ory: Program Staff = 248		Position Category: Adminis. Staff N = 83				Position Category: Both N = 52			
Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
3.233	1.090	17	3.333	3.452	0.950	0	3.269	3.250	0.772
3.195	1.041	15	3.412	3.500	0.996	0	3.038	3.000	0.949
3.268	1.052	17	3.439	3.607	1.025	2	3.100	3.132	0.863
3.602	1.010	11	3.611	3.643	0.897	0	3.577	3.750	0.997
3.561	1.023	11	3.806	3.905	0.866	0	3.519	3.660	0.896
3.227	1.056	17	3.591	3.595	1.007	1	3.314	3.250	0.948
3.364	1.148	12	3.746	3.879	0.967	1	3.490	3.472	1.007
3.293	1.069	18	3.538	3.481	0.937	0	3.327	3.375	1.004
3.109	1.180	19	3.516	3.431	0.816	3	2.939	3.000	1.029
3.040	1.049	20	3.333	3.360	0.861	1	2.882	2.913	0.887
3.173	1.107	18	3.462	3.641	0.920	1	3.157	3.200	1.027
3.280	1.107	32	3.294	3.238	1.082	7	3.378	3.417	0.936
3.233	1.045	25	3.448	3.417	0.841	4	3.208	3.313	0.944

RESPONSE IN TEN INSTITUTIONS TO ISSQ
BY POSITION OF STAFF

Item No.	Position Category: Program Staff N = 248				Position Category: Adminis. Staff N = 83				Posit
	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data
27	89	3.025	3.000	1.136	20	3.286	3.360	0.958	8
28	24	3.366	3.559	1.124	15	3.603	3.587	0.964	5
29	13	3.434	3.564	1.062	8	3.680	3.708	0.738	1
30	67	2.608	2.532	1.172	20	2.683	2.750	1.045	4
31	53	2.492	2.469	1.181	24	2.661	2.675	1.108	6
32	27	3.276	3.323	1.116	9	3.135	3.136	1.051	1
33	54	2.814	2.828	1.229	9	2.986	3.019	1.066	2
34	38	3.100	3.173	1.143	8	3.120	3.074	1.115	4
35	70	3.129	3.167	1.160	9	3.500	3.537	0.954	4
36	26	3.288	3.342	1.045	15	2.956	2.917	0.984	4
37	88	3.037	3.063	1.110	27	3.089	3.077	1.066	5
38	25	3.565	3.673	1.028	10	3.699	3.829	0.938	0
39	43	3.307	3.329	0.959	10	3.397	3.444	0.829	0

RESPONSE IN TEN INSTITUTIONS TO ISSQ BY POSITION OF STAFF

gory: Program Staff = 248		Position Category: Adminis. Staff N = 83				Position Category: Both N = 52			
Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation	Missing Data	Mean	Median	Standard Deviation
3.000	1.136	20	3.286	3.360	0.958	8	3.159	3.233	0.963
3.559	1.124	15	3.603	3.587	0.964	5	3.426	3.528	1.016
3.564	1.062	8	3.680	3.708	0.738	1	3.431	3.563	0.855
2.532	1.172	20	2.683	2.750	1.045	4	2.375	2.357	1.064
2.469	1.181	24	2.661	2.675	1.108	6	2.217	2.125	1.031
3.323	1.116	9	3.135	3.136	1.051	1	3.137	3.125	0.980
2.828	1.229	9	2.986	3.019	1.066	2	2.620	2.618	1.008
3.173	1.143	8	3.120	3.074	1.115	4	2.604	2.700	0.939
3.167	1.160	9	3.500	3.537	0.954	4	3.000	3.125	1.092
3.342	1.045	15	2.956	2.917	0.984	4	2.250	2.214	1.042
3.063	1.110	27	3.089	3.077	1.066	5	2.830	2.824	0.940
3.673	1.028	10	3.699	3.829	0.938	0	3.269	3.382	1.012
3.329	0.959	10	3.397	3.444	0.829	0	3.019	2.974	1.000

between the variables of staff role and sex, four items--36, 43, 50 and 60 (labeled "A" in the listing)--which elicited role-related instrument response differences, were also found to elicit sex-related response differences. Two items, 19 and 22(B), were present on both the age-related and role-related rosters, and one item--75(A-B)--appeared to discriminate among the responses of staff, whether they were classified by sex, age or work role.

A brief summary of finds to this point indicates that 39 items on the ISSQ are sensitive (yield response discriminations) to one or more of the three population variables employed in collecting data from child care staff. We also note that the variables of sex and work role appear to be somewhat more discriminating of item response than age. And finally, we learned that 16 percent of the solicited response to the ISSQ proved to be missing or unavailable. This is a considerable response deficit; one which argues persuasively for the need to provide child care staff with more encouragement to respond productively whenever possible to ISSQ material, and also suggests the corollary need for closer monitoring of the conditions under which the survey is conducted than may have been observed in our work. For the moment we intend to explore the missing data experience more deeply to determine whether it may yield additional insights into the contemporary dynamics of child care residential agency programs.

One observation emerges conspicuously. That is, there is marked unevenness in the amount of missing data found among the eighty items of the ISSQ response. The variability of the data deficiency extends over the range from item 80, which had a low of eight missing responses of a possible 422 responses (1.8%), to items 69 and 72 each with 175 missing responses, again associated with 422 possible responses (41%). This unsymmetrical spread clearly testifies against the inference that staff was simply antagonistic to, or resistant to, the survey activity. What then might explain the irregular pattern of response failure? We conjectured that it might be tied to selective item content, and decided to inspect the extent to which staff across the 10 residential agencies lacked knowledge, or, somehow, found it difficult or uncomfortable to transmit information about certain agency-related content areas. More precisely we attempted to learn whether the rate of missing item data (average per item) fluctuated across the five intuitively defined content areas already described. These findings are now reported:

Content Area	Item Numbers	Missing Response Per Item/Per Person
Treatment Program	1-29	60.72
Community Interaction	30-37	71.75
Evaluative	38-43	53.67
Staff Development	44-54	35.73
General Organization	55-80	66.27

245, 246, 247, 248, 249, 250, 251, 253
252,

The response differential is appreciable. Staff appear to be best informed and best able or willing to express themselves with regard to staff development practices in their agency settings. Of interest also is the relatively high rate of information provided in connection with the class of evaluative items. We may wonder whether the rather productive response in this content area reflects the staff's increasing dedication to the nationwide preoccupation with agency accountability and the recurring admonishments for greater attention to program evaluation responsibilities. The response differential also reveals a disconcertingly poor informational return for the community interaction class of items. We must be impressed with the inference suggested by this finding that child care workers in California remain all too institution- or agency-bound, and only marginally conversant or communicative about their communities.

We now want to turn to our second question--How do the subgroups within each population class perform on the total ISSQ? That is, how do the two sexes, or the four age groups or the staff in the three types of agency roles differ in their global reaction to the ISSQ?

B. The Staff Focus

In the preceding section we have documented an array of statistically reliable item differences on the ISSQ as the specific items in the survey instrument were associated with the sex, age and working roles of child care staff. We now plan to ask the related question having to do with the possible association between these population variables and the global response to the ISSQ. That is, while female staff may be found to be more outspoken about their negative feelings, or while they may in fact harbor more negative feelings than their male colleagues with respect to one or another element of agency programming, we are interested in learning whether this difference is directionally consistent in the total test response. Do female staff generally express more dissatisfaction than male staff with agency performance? Is one age group of staff generally more satisfied with residential programming than other age groups?

We approach this problem remembering that the answer options to each survey item ranged from 1 (poor) to 5 (excellent), and that we have computed scores for any of a number of population groups by generating group average scores. Thus group scores for male and female staff by item were reported in Table 7. Our present interest is in transforming the average or group scores on each item to ranks. To accomplish this for the data reported for the two sexes we simply assign the rank 1 to the larger of the two average scores, and the rank 2 to the lesser. (The very same operation can be followed for "age" using four ranks, and for "working role" using three ranks.)

If we then sum the ranks as values over the 80 items independently for male staff and female staff, we can determine how closely our empirical data conform to chance. Presumably, if chance were operating alone, the ranks should sum to 120 for each sex. They, in fact, sum to 84 for male and to 156 for female staff. Therefore, the evidence from this study clearly argues against chance. That is, male staff members from the ten California agencies completing the ISSQ perceive agency conditions more positively (to be more proficient) than do female staff members on 76 of the 80 survey items. Female staff report more positive information than male staff on only four of the eighty items (2, 11, 72 and 73). To all appearances then, male and female staff respond amazingly differently with regard to their value orientations when asked to assess the child residential care settings in which they work. Male staff are far more charitable: female staff are quite uniformly more critical and uncomplimentary. How or whether such differences may be expressed or translated into individual day-to-day work behaviors remains an interesting issue for speculation.

We now turn to the data in Tables 8 and 9 to develop the above approach to the parallel age and working role data. These data are not as devastatingly impressive as were the sex-related data. Nevertheless, they do certify the importance of these two remaining population characteristics for understanding the ISSQ response we have reported. Working first with the age partitioned data we assign rank 1 on each survey item to that age group which produces the most positive group response, through to rank 4 to that group which has the least positive (lowest) average score for the item. The summated ranks for items are:

Age Group	Summated Ranks*
20-29	162
30-39	231.5
40-49	260
50-59	146.5

By chance we would expect a rank summation of 200 for each of the four age groups. What do our data show? The two extreme age groups (the youngest and the oldest) tend to have a more generous set in reporting conditions in child care agencies than do the staff in their thirties and forties. The oldest group (50+) seems to be the most mellow and positive in their orientation. In striking contrast is the neighboring group in the 40-49 age class, which appears to be the hypercritical group. Whether these findings suggest that apathy follows on the heels of discontent, or that increasing experience helps staff modulate intense dissatisfaction into reasoned perspective is, of course, not forthcoming from our data.

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*A coefficient of concordance (W=.28) was calculated for these data suggesting a modest relationship between age and projected adequacy of agency programming. The credibility of this statistic suffers from the fact there are varying amounts of missing data, and therefore varying representations of participating staff in the reported response values across items.

Employing the same method of approach to the variable "staff role" the following rank sums were calculated:

Staff Roles	Summated Ranks*
Program Treatment	188
Administrative/Support	97
Both	195

If chance were the sole condition operating here we would expect each of the role classes to exhibit an equal rank sum of 160. The data, therefore, provide evidence of rather significant departure from chance findings with administrative staff being most sympathetic to and supportive of program activity across the ten California child care settings. The two role classes, Program Treatment and Both, proved to respond quite similarly so that they virtually behaved as a single homogeneous group--considerably more harsh in viewing child care programs than were administrative staff.

C. Integration

Numerous lines of inquiry give confirmation to the position that the ISSQ elicits importantly different views of the working conditions and program activities in child care agencies. The evidence for this position was obtained in terms of the amount of data collected, and the type of data collected on the ISSQ on the individual item level, on groups of intuitively organized or clustered items as well as across the total array of eighty items which constitute the survey instrument.

What are the implications of this work? First, it would appear that the information reported on the dimension of missing data suggests that this ISSQ index may be useful in defining the hierarchy of interest patterns present in the cognitive life style of staff working in a child care agency. In this sense, the ISSQ may have some value (administered as it was in this study) for disclosing major patterns of motivation which tend to impede or enhance program change and program implementation in agencies serving children. The totality of these results suggests that the means by which staff are selected to represent an agency in responding to the ISSQ may be unusually critical in deriving a fair picture of the agency from the survey instrument. The latter conclusion is most vitally true if the purpose of such a survey is to draw comparison between agencies, between departments within or across agencies, or within an agency division at successive points in time.

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*The coefficient of concordance was employed again with this data and yields the relation W=.47, suggesting a moderate relationship between the variable of staff role and staff perception of the adequacy of residential programs.

V. Observations or "Learnings" with Reference to the Research Questions Addressed by this Project

In this concluding chapter we restate the project's main research questions and interpret in summary form what we have learned with reference to them--and to the more general question of the characteristics that seem associated with superior organizational performance in the child care field.*

Several factors seem to have major bearing upon whether a child care (or any) institution is likely to try reportedly valuable and available innovations in practice or program that seem promising for improvement of mission achievement. These factors have been summarized by Glaser, with additional material added from Howard Davis and George Fairweather, and are attached in Appendix A. The summary comments below will deal primarily with new insights or emphases gained from the experience on this project, but also will refer to learnings that merely add confirmation to similar findings previously reported in the literature. "Experience on this project," incidentally, is not limited to the data and documentation which grew out of HIRI's intensive work with the four institutions in the consultation group. It includes site visit observations and program analysis with regard to institutions in the comparison group, such as the Yakima Valley Training School, Devereaux Schools, Youth Adventures, and other institutions in our comparison group.

Q:	Under what conditions do institutions consider and implement newly defined programs and practices which may be expected to maximize the likelihood of client rehabilitation or developmental progress?

A: The evidence from this project is in accord with general findings in the literature (Glaser, "A Distillation of Principles for Research Utilization," NIMH, 1971, now in process of revision) regarding the factors or conditions that facilitate an institution's active search for and serious consideration of new ideas for improvement of its services and organizational effectiveness.

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*Superior organizational performance in this context has been judged on the basis of: (1) evidence of unusually successful outcomes in relation to institution mission; e.g., for an institution dealing with young persons classified by courts or probation departments as "delinquent," unusually low recidivism rate as well as evidence of superior developmental gain in constructive behavior patterns, school achievement, etc., compared with baseline data upon entry; (2) reputation and nomination in the judgment of peer institutions or knowledgeable persons in the child care field; (3) site visit observations of program, records, and staff-child interactions; (4) overall scores on the Baseline Data Form.

An important finding from several studies in the literature is that "when an organization becomes involved in critical self-examination of its goals, opportunities, modus operandi and problems, its own staff tends not only to seek new ways of improving performance, but in that process a climate is created which makes for readiness or openness to consider seemingly relevant R&D findings or innovations developed by others." Observations from the present study would suggest an important modification or condition to the above generalization, namely that this is likely to hold true only when (1) the climate for critical self-examination is hospitable, encouraging, and rewarding; (2) there is relative freedom from serious, pervasive internal power struggles or animosities among key staff; and (3) there is sustained commitment, monitoring, follow-through and positive reinforcement for such a procedure by consensually accepted "powers that be" in the given situation. While the above observations probably would hold true in general, they seem especially applicable to child care institutions. There the various components in the setup, such as school personnel, social workers, counselors, recreation staff, cottage or dormitory staff, etc., are more closely interrelated with reference to the child development mission than are various divisions or "profit centers" in an industrial organization.

A particular learning from this project, which is touched on only peripherally in the literature, is the need for an organization not to be "a house deeply divided against or within itself" if innovative ideas or procedures are to take root and survive. When an appreciable portion of the staff's energies is channeled into internal jockeying for power, as was the situation in VBC, or into depressive withdrawal, as at Southside during the time of our consultation, there is not enough sustained commitment from a sufficiently broad base of support...for innovations to get the nurture and care they need in the early stages of tryout, in which case they tend to wither and die. For example, when an all-day presentation of a new procedure for individualized goal planning was made available to all four of the institutions which received HIRI consultation, LCCH found it very profitable and Red Rock, while critical of the consultant's presentation on the subject, "bounced from disagreement with his point of view to a constructive alternative." Thus, LCCH and Red Rock had "learning readiness" to consider and adapt something from the outside that meshed with their internal desire to do a better programming job for and with each child. At VBC and Southside, where there was not this general open climate of eager, consensual readiness to consider the ideas presented, even if there was rejection of specific recommended procedures, the presentation bore little or no fruit. Similarly, the role negotiation exercise which led to constructive results at Red Rock and LCCH, where it had first been tried by the primary consultants to those two institutions, proved of no lasting value at VBC and may have done more harm than good. (It was not tried at Southside.) At VBC it seemed to intensify the divisiveness, since some persons gained power from it and others felt they lost power. It did not help to resolve VBC's basic problems and tensions. Again, this observation may be especially valid for institutions such as a child care treatment center or a hospital, where the various staff functions are so vitally interconnected with the institution's mission. On the other hand, power struggles among divisions within a corporation seem to go on almost characteristically without necessarily having disastrous effects. In fact, competitiveness and jockeying for ascendency within certain types of corporate structures may even serve to sharpen creativity and performance results. And the Oakland Athletics, a baseball team noted for internal disharmony but also noted for great talent, was able to win the 1972-73-74 World Series. There seemed to be sufficient motivators for the talent to shine through in a competitive situation and win. One may wonder what would happen if Oakland were to meet a team with equal talent and appreciably better harmony!

Sometimes, under certain conditions and suitable "therapeutic procedures" the factors which seem to be causing the divisiveness and disharmony can be corrected within the given body politic. In other cases the particular combination of personalities and chronic dissonances are so likely to make for new outcroppings of crippling disorder that the most promising remedial action may be through major or at least key changes in the cast of characters involved as well as perhaps in the organizational structure.

At VBC, the route taken has been both a drastic change of cast and of organizational arrangements. It will take time to observe the consequences of those changes. At least the new personnel enter with hope and are not mired in the previous imbroglios. At Southside the major change was in the new director, who was not involved in the internal frictions which preceded him, and who was looked upon with anticipation (aside from possible misgivings stemming from uncertainty) by the great majority of the staff. This in turn has provided support for and more trustful participation in efforts to bring about renewal.

In the cases of Red Rock and LCCH, these institutions were basically in healthy condition at the start of the consultation intervention, but with all the normal problems, differences, and dissatisfactions with the status quo--thus offering opportunities for improvement. However, they were not suffering from intractable hostilities or distrust. They were cohesively animated toward becoming ever more effective in relation to changing times. Thus the soil was favorable to their profiting from consultation. According to the evidence adduced in previous sections of this report, they did so profit. The consultation appears to have helped them develop some new ways of insuring their own vitality and viability in the direction of maintaining a growing edge for mission achievement.

Q: In what ways do (child care) institutions that develop seemingly exemplary programs and achieve relatively superior outcomes differ from institutions that offer less effective programs for similar clients?

A: The observations in response to the previous question bear upon the answers to this one. Institutions that develop seemingly exemplary programs and achieve relatively superior outcomes tend to have a quality of leadership that in one way or another sparks drive and shared commitment by organizational members to bring about effective mission performance that is focused on providing a superior service or product or outcome for its clients.

Aside from the affective "sparking" in one way or another toward a sense of caring about the institution's mission and effective task performance, the institutions that develop seemingly exemplary programs seem to demonstrate better managerial skills and modus operandi to carry out the functions of planning, organizing, staffing, coordinating, motivating and controlling. Those "better managerial skills" seem to include the development of organizational structures that provide a capability to identify and analyze problems; to search critically for information that might bear on solutions to those problems; to generate and modify solutions; to implement those solutions effectively; and to assess their impact over time. However, if the organizational house is excessively "divided against itself," latent capabilities for effective performance of the above managerial functions cannot be brought to healthy fruition until that climate is basically improved.

Further, the more effective institutions seem to differ from the less effective not only in seeking to identify, build upon and affirm individuals for their strengths, but by the same token do not expect them to perform tasks beyond their capabilities and thus do not settle for substandard work performance. While they have an affirming ambience, they also tend to maintain legitimate high standards for relevantly excellent performance of the tasks that appear related to mission achievement. They either help individual staff members or group task teams achieve those standards, or get persons who have the necessary qualifications to so perform... and the director usually has the authority to restaff if necessary. Several institutions in our comparison group give testimony to the validity of this observation.

The institutions that develop seemingly exemplary programs tend to have a greater spirit of what might be termed "creative discontent" than the institutions that offer less effective programs for their clients. They tend to welcome, or at least respond with interest rather than defensiveness to legitimate challenge, and to adopt a problem-solving posture. At VBC, however, and to a lesser extent at Southside, almost every question about the worth of certain things they were doing, or the possible value of trying some other things they were not doing, or the possibility of changing priorities...tended to be perceived by some members of the staff as a criticism or lack of appreciation for their accomplishments.

Child care institutions that develop more effective programs tend to be user-oriented; that is, they tend to measure their program effectiveness in terms of impact upon their constituencies. In these institutions, those constituencies are first of all the children entrusted to their care, then parents, referring agencies, and the communities to which these temporary institutional residents are likely to return. Staff comfort or staff satisfaction with program is down toward the bottom of the list on measures of program value. Institutions that tend to offer less effective programs for their clients do not focus on goal planning and coordination of program elements (such as through organization into treatment teams) for goal attainment with individual clients. Rather, they concentrate on their specialty, whether that happens to be school teaching, social work, child care work in a cottage, speech therapy, psychology, etc. There is a lack of system integration, which in turn often is related to leadership style, serious internal power struggles, bad feeling among individuals and task groups, lack of shared commitment, poor three-way communication (down, up and laterally), unsuitable organization structure, inadequate feedback of performance in relation to consensually agreed upon goals, incompetent, or inadequately trained personnel, etc.

Q: In what ways, in the course of consultation, can the seemingly less effective institutions be helped to become more effective in relation to their own potentialities and treatment objectives for the populations they serve?

A: Any institution--the more effective or the less effective ones--probably can be helped through consultation that starts with some appropriate-to-the-situation fact and perception finding inquiry or survey (with the approval of those concerned). The purpose of the survey would be to obtain information about problems, opportunities, what has been done or attempted with regard to those matters heretofore, with what results, and who wants (or doesn't want) what from the relationship with the consultant.

Related matters that need to be talked through early in the consultation are: what order of priority of things to focus on in the consultation; how best to proceed; at what pace; who to work through as the primary contact persons in the client organization (or work with in tandem team effort). Decisions arrived at with regard to such questions are related to matters of client readiness, consultant style or judgment, and the agreed-upon scope and time availability for the consulting effort.

Some more basic questions for the consultant to have in mind as he thinks about and perhaps undertakes a personal interview survey with the staff of a child care institution are:

1. What seems to be the climate or degree of mutual respect and trust among the people who staff the institution--with those administratively above them, with persons in other departments, with peers and colleagues, with supervisees? If there seems to be excessive and nonproductive infighting or power struggles or relevant animosities, why and what might be done to reduce or overcome this?

2. Is there a practice of informal as well as perhaps occasional formal organizational self-challenge, including elements such as goal review, criteria for goal attainment, nondefensive evaluation of program or general modus operandi in relation to goal attainment, and willingness to "face facts" and take corrective action when-if needed? Are there organizational vehicles for doing these things?

3. Is there coordinated team involvement in individualized goal and treatment planning for each child?

4. Are there appropriate organizational vehicles for effective service delivery--for the implementation of treatment plans, the evaluation of each child's progress in relation to the treatment plans?

5. Is the child himself, insofar as practicable (and parents or possibly concerned others, such as the referring agency), invited to participate in formulating the individualized treatment plan?

6. To what extent does the institution staff try to keep up with promising relevant innovations by others that might offer ideas for improved policy or practice or procedure in their own settings?

7. How well are the management functions of the institution being carried out: planning, organizing, staffing, coordinating, motivating, controlling?

8. In summary, does essentially the entire staff seem to know and agree upon what the institution is trying to do, how to go about doing it, what progress is being made, what problems are encountered... and is problem solving undertaken in a spirit of trustful collaboration and generally mutual respect? If so, hooray--for that would constitute an unusually healthy and constructive state of affairs. If not, then there are problems affecting organizational health and viability that call for creative remedial efforts.

One such effort that may be helpful is for a consultant to see whether the director would approve a confidential interview with each key individual (and with a representative sample of the institution's clients, if feasible), inviting open-ended response to a question such as: "If you were the chief executive here and had the authority to do whatever you thought wise/desirable, what changes would you make--and why? What would you do that isn't being done, what would you stop doing that is being done, or in what ways or where would you change the emphasis? How might the institution be made still more effective and satisfying for all parties concerned?" The consultant then would collate the confidential inputs into a report, with feedback first to top management, then at least to all who contributed to the survey. A next step would be to undertake problem analysis and problem solving--often through the mechanism of small volunteer ad hoc committees who can study given issues and report back to the appropriate group with recommendations, with decision making by those responsible for given types of decisions.

To summarize in a slightly different way, what is the institution's behavior pattern or style with regard to: (a) sense of shared commitment to common goals and excellence in task performance; (b) focus on the child and involvement of the child and relevant others in his treatment plan; (c) concern for organizational renewal and internal integration by staff, board and clients (to the extent practical), with a constant focus on the institution's raison d' etre in relation to available resources; (d) tie-in with community activities and resources; (e) openness to consideration of promising innovations or exemplary practices by others in the child development field; (f) mutual adaptation of the

> organization and its environment; (g) implementation of the major functions of management?
>
> One other way in which a child care institution (with or without consultation help, but "with" is likely to yield better results) can progress toward becoming more productive in relation to its own potentialities and treatment objectives might be to administer the Institution Self-Study Questionnaire (ISSQ) developed by HIRI in the course of this project. The 80 items in the ISSQ have been carefully selected and refined to reflect institutional practices that have consensual support in the "state-of-the-art" literature as being desirable, constructive and beneficial to all concerned. If an institution's staff rates its organization toward the undesirable side with regard to given items, such ratings constitute a means for identifying problems and inviting staff collaboration in analysis and improvement efforts, followed by subsequent reevaluation. A vehicle for moving in the direction of continuous self-renewal thus is introduced.

Aside from learnings related to the specific research questions addressed by this project, in our first progress report to OCD dated April 1972, we summarized our tentative findings or impressions based upon site visits and interviews with the director and certain staff members at 20 children's residential centers, aside from HIRI staff members' acquaintance with many more such institutions than the ones visited in connection with this study. We will quote from that report with only a few modifications, because the early findings seem to have been substantiated with wider experience.

> The project began August 1, 1971. Our first efforts consisted of developing an observational and interview schedule so that highly relevant data could be fathered systematically by almost any well-trained and sophisticated observer. To this end we initially paid a number of short site visits to smaller institutions, especially institutions that had a widespread reputation of offering unusually effective programs. Out of these site visits emerged a number of observational categories which in turn evolved through four revisions into a relatively systematic and comprehensive observation and interview schedule. With such an observational framework in hand (usually) two trained interviewers made subsequent site visits to 13 institutions that offer residential care for children in the three diagnostic categories (mentally retarded, emotionally disturbed, delinquent). Institutions visited were primarily in the State of California, but some were in Oregon and Washington and one was in the State of New York.
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> Following the site visits, each observer wrote an independent report on his observations. Although much of the data contained in the reports of

these site visits and observations have not (at the time of this report) been summarized thoroughly, certain findings seem to be emerging. These findings are still rather tentative and subject to modification as we become acquainted with a larger sample of institutions, but they may be stated as follows:

A. "All Organizations on This Side of Paradise Seem to Have Their Own Kinds of Strengths and Limitations"

Institutions offering residential care for children vary widely. Each seems to have special strengths, but even the "strongest" has its own set of limitations and the "weakest" appear to have some particular strengths.

B. Leader Qualities

Leaders of effective institutions appear to be active, vigorous, information-seeking and change-initiating individuals. They seem clear about the direction they want the institution to take and sophisticated about the programs which express that institutional philosophy. If they themselves do not have highly developed professional skills as "rehabilitators," they have identified and depend upon particular capable staff members for help in program development and certain operating decisions.

These leaders do not shrink from considering and sometimes making major changes. Although they are sensitive to organizational constraints and staff resistance to change (they are in touch with staff politics and individual staff weaknesses and strengths), they appear determined to make changes which seem necessary and desirable. They plan carefully to meet resistance to change and invest a constant and determined effort over the long term to counteract those resistances. Such pressures sometimes result in the resignation of staff members who find the changes philosophically unacceptable. Although many of the leaders appear secretly to wish to mandate changes by fiat and simply replace those staff members who might resist the changes, most appear unwilling or unable to bring themselves to do so, except as the result of unusual provocation or threat.

In all of this process, then, they are politically sensitive, balancing their desire to make changes against risks of precipitating chaos or inflicting unnecessary damage on individual staff members. However, they appear to be a determined bunch and, as a result of their canniness and determination, seem to prevail over the long term.

C. Staff Selection and Maintenance

Within each institution that seemed to have progressive and unusually effective programs, we found that the leader has been able either to recruit a number of competent helpers from within the staff, or to introduce competent new staff who not only are dedicated to providing excellent care for their clients, but who understand and support the general institutional philosophy. Staff commitment to program philosophy is absolutely necessary if serious internal friction and divisiveness are to be avoided, and especially if changes are to be implemented. Additionally, the staff members that assist the leader seem to be energetic and articulate with relatively low turnover within their ranks.

D. Organizational Climate

The organizational climate among the institutions with unusually effective programs seems to be one that encourages a self-challenging attitude and the tryout of promising new procedures and practices. Changes are instituted from time to time (often experimentally, on a limited basis) in a continuing search for improved outcomes for the institution's client population, and for seemingly better ways of institutional operation which may or may not directly affect client rehabilitation. Outcomes are predicted, evaluated, and in some cases, quantitatively measured. If a change is found to introduce a new set of side effects or is not working as well as expected, it in turn tends to be open to reexamination and modification. Although we found different ways of making decisions about changing, each institution that had unusually effective programs in its field of service seems to have an established procedure by which changes can be introduced. For some of the institutions, especially the smaller and newer ones, there is much active staff participation in policy discussion, decision making and the suggesting and implementing of new procedures.

These highly effective organizations additionally possess superior communications networks; accurate efficient messages go back and forth quickly within the institution. Sometimes these messages are conveyed in a "stand up" conference, sometimes by written memo, sometimes by telephone, sometimes by larger planned meetings.

E. Staff Support

When institutions that seem unusually effective make changes, they do not do so arbitrarily, impulsively or frivolously but build staff consensus as the changes are made. They do not wish to traumatize

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unnecessarily the staff or the population served. However, once decisions for changes have been reached, a conscious program to develop staff consensus is instituted, making reasonable compromises whenever appropriate and providing training to prepare staff to do their new jobs and give them confidence that they can do them well. The best training tends to be highly task-related and explicit regarding new expectations. Personnel learn what they should be doing and how to tell how well they are doing it.

In these institutions, maximal efforts to monitor implementation are made with the help of accountability systems, and such follow-up becomes embedded in the institutional procedures through training and supervision. Efforts to make changes are taken seriously and pressure to do so is maintained over the long term.

F. Organizational Skill in Implementing Change

Although there appears to be a relationship between the recognized competence of institutions in their field of service and their ability to make changes, that relationship is not simple: some first-rate places may be so committed to an existing therapeutic or institutional philosophy that making basic changes would be difficult. (On the other hand, if an institution is good and is doing its job, there may be no reason to make basic changes.)

G. Adequate Plant Facilities, Equipment and Financing

We observed that institutions with unusually effective programs tended to have adequate (but not necessarily modern) buildings, grounds, equipment, and no crushing burden of fiscal load or perpetual fiscal uncertainties. On the other hand, there are institutions not considered unusually effective which also possess this equipment and fiscal solidity. Thus we concluded that while such may be very helpful, it is not by itself sufficient. And some institutions with very limited facilities seem ingenious and resourceful in finding ways to achieve their objectives with practically no increase in costs.

H. Contact with Outside Community and Sources of Innovation

The effective child care institution is characterized by frequent interchange with the outside community, especially professional persons and other agencies. This contact often is initiated from within the institution. Once a solid reputation has been established, the many visitors to such an institution bring in ideas and interchange. Additionally, the institutions with active rehabilitation programs seem to make definite and successful efforts at contacting the parents of their client population, and inviting input from the clients themselves (where feasible) regarding the treatment plan for them as well as the institution's operation. (Yakima Valley School would be one outstanding example of this observation.)

With regard to factors associated with the likelihood of change in an institution--i.e., with facilitating or inhibiting change--we have identified the following:

a. Staff support

When a given change has been carefully considered and legitimately decided, it may be necessary to part company with staff members who cannot accept and would try to sabotage such changes. Or (at least) it may be necessary to neutralize their influence on operations or policy. Such steps may become particularly necessary when changes are perceived as running contrary to ideological or political commitments of certain influential staff members.

b. Appropriate internal organization

The way organizations function internally can be appropriate or inappropriate for the changes desired. When program changes are made, organizational format should be reexamined to judge whether it appears to be consistent with the change.

c. Accountability

Staff consciousness of organizational effectiveness in terms of outcomes for clients provides an incentive for wanting to improve. Accountability measures and performance feedback can provide staff with a realistic basis for knowing how well they are doing and, when innovations are tried, measuring their progress (as contrasted with more unusual performance measures based on factors unrelated to outcomes).

d. The explicitness of what is expected

The more concrete and explicit the expectations for changed job behavior (when that is called for), the easier it is for staff to learn what they should do. Some new desired job behaviors may be identified by supervisors and by the staff themselves, while others may have to be developed, experimentally, in the process of implementing the change. Concreteness facilitates demonstration and role modeling and provides a basis for reinforcing desirable behavior.

In our Progress Report dated February 1973, we offered some further tentative findings. They are repeated here with some modifications.

> The tentative findings (really, hypotheses) suggested herewith resulted from the first six months of intensive consultation with four institutions. They evolved from the laborious and painstaking process of helping institution staffs confront and struggle with some of their problems.
>
> 1. Organizational effectiveness in children's residential institutions
>
>   (a) An effective staff is oriented primarily to thoughtfully planned and integrated treatment of clients rather than to short-term resolution of crises. The phrase "thoughtfully planned and integrated" is intended to imply not only team planning by the various relevant persons or components of the institution's staff, but also planning and integration with the child himself to the extent feasible, with an appropriate representative of the referral agency, and with the parents or foster parents or whomever the child is likely to reside with when he leaves the institution.
>
>   (b) Questions of who in an organization has the authority and responsibility for what kinds of decisions, what other persons or groups should be invited to provide input to those decisions before they are made, who should be advised promptly after given kinds of matters are decided... should be made explicit, and be subject to review if some members of the organization feel that the established modus operandi does not seem to work well. It is better to surface and deal with possible disagreements or negative feelings rather than allow them to fester.
>
>   (c) Staff effectiveness may be enhanced if they are organized into task-oriented teams, rather than into discrete professional entities. This implies that the staff members have explicit skills in planning and problem solving, and that, when those skills are lacking, explicit training will be provided to develop or strengthen them.
>
>   (d) Only when an institution's concept of its mission is identified and agreed upon can the institution expect its staff to establish appropriate treatment goals.
>
>   (e) It is ineffective to have components of the institution functioning in isolation. Treatment plans should not be formulated by one professional group for implementation by another, without participation of the latter group.

(f) If a staff in an institution is absorbed in hostile, fragmenting power struggles or withdrawn into self-contained, "walled-off" units, such unhealthy manifestations of dysfunction need to be dealt with in some way that firmly resolves the problems and enables the group to become integrated in a reasonably trustful, mutually respecting way before much of anything else of lasting value can be accomplished.

2. Providing effective consultation

(a) An effective consultant is open to inputs from the consultees and maintains flexibility regarding his consultation plan.

(b) It is helpful to have an ample preliminary period during which the consultant is visible and available to the consultees, builds a relationship with them, and during which time his function can be properly interpreted.

(c) An effective consultant is explicit in his communications, making clear his purposes and methods, and informing the group as he moves from one phase of the consultation to another. Communication should be two-way, allowing the consultees opportunity to make impact on the consultant as well as vice versa.

(d) An effective consultant takes the initiative (when necessary) in identifying problems, defining issues, clarifying roles, including his own, and sharing his perceptions with the consultees for their response and concurrence--or otherwise.

(e) The consultant's effectiveness is enhanced if he has a responsible audience: for example, a specific planning group within the institution, approved and supported by the director, that will take the responsibility of post-consultation implementation in return for the consultant's efforts. This is usually implemented by an agreement or contract whereby the two parties agree to work jointly to reach specified objectives.

Many of these "learnings" are not new. Some of the observations and data accumulated from this study provide only cross-validation of existing observations reported in the literature rather than new knowledge. Some others, however, are new either in substance, context or emphasis.

While the observations offered above have had child care institutions in particular focus and our data base is drawn largely from this study, the HIRI study and consultation team is aware also of the larger literature on organizational effectiveness and the factors related to facilitation of planned change.

Some members of the team have had broad and long consulting experience. From all of the above, there is reason to believe that many (but not all) of the observations or "learnings" presented in this chapter would have relevance to various types of organizations, rather than only child care institutions.

APPENDIX A

A CHECKLIST FOR CHANGE THROUGH RESEARCH UTILIZATION*

(A behavioral model for change developed by Howard R. Davis, PhD
based on learning theory, and converted into a recallable acronym:
A VICTORY)

This checklist is intended to serve as a guide rather than as an outline for a systematic plan to bring about change. All factors interact, so that a given manipulation to increase the probability of desired results could influence more than one factor.

ABILITY

______ Are staff skills and knowledge appropriate to accommodate the desired change?

______ Are fiscal and physical resources adequate for the change?

VALUES

______ Is the change consonant with the social, religious, political, ethnic values of the beneficiaries?

______ Is the change consonant with the philosophies and policies of the program supporters?

______ Is the change consonant with the personal and professional values of staff?

______ Is the top man in the organization in support of the desired change?

______ Are the characteristics of the organization such as to render change likely?

INFORMATION

______ Is information on the desired change clear?

______ Does information about the idea bear close relevance to the improvement needed?

______ Is the idea behind the desired change one that is "tryable," observable, of demonstrated advantage, etc.?

CIRCUMSTANCES

______ Are conditions at this setting similar to those where the idea was demonstrated to be effective?

______ Does the present situation seem to be conducive to successful adoption of this particular plan?

TIMING

______ Is this a propitious time to implement this plan?

______ Are other events going on or about to occur which could bear on the response to this change?

OBLIGATION

______ Has the need for this change been ascertained through sound evaluation?

______ Has the need for this change been compared with other needs in this program?

RESISTANCES

______ Have all reasons for *not* adopting this change been considered?

______ Has consideration been given to what may have to be abandoned if this plan is launched?

______ Has consideration been given to all who would lose in this change?

YIELD

______ Has the soundness of evidence about the benefits of this proposal been carefully assessed?

______ Have possible indirect rewards for this change been examined?

---

*National Institute of Mental Health. Planning for creative change in mental health services: A manual on research utilization. Washington, D.C.: National Institute of Mental Health, 1971, Publication No. (HSM) 71-9059, p. 30.

APPENDIX B

INSTITUTION SELF-STUDY QUESTIONNAIRE (ISSQ)

FOR CHILDREN'S RESIDENTIAL INSTITUTIONS

Introduction

The main purpose of this questionnaire is to serve as a means of reflecting on the features of life and work at a child-care institution. In a preliminary tryout of an earlier edition the staffs of a number of institutions found the items useful for stimulating self-challenge--or review of their own goals, programs, and goal-attainment progress.

Directions

In responding to the items in this questionnaire, select an answer from the given possibilities as the item applies to your particular institution, in your opinion. PLEASE INDICATE YOUR ANSWERS ON THE SEPARATE ANSWER SHEET ATTACHED.

This instrument was developed in 1972-74 by Edward M. Glaser, PhD, in the course of carrying out a grant (OCD-CB-102) by the Office of Child Development to the Human Interaction Research Institute, Los Angeles

INSTITUTION SELF-STUDY QUESTIONNAIRE (ISSQ) ANSWER SHEET

NAME OF INSTITUTION________________________________ DATE______________

RESPONDENT'S

AGE:
___20-29
___30-39
___40-49
___50 or over

SEX:
___M
___F

POSITION:
___1. Program/Treatment Staff (social worker, child care worker, counselor, etc.)
___2. Support Staff (clerical, food service, maintenance housekeeping, etc.)
___3. Administrative Staff (director, assistant director, supervisor, etc.)
___4. More than one position (e.g., if Program and Administrative, check 1 and 3)

Answer Scale:

5 Excellent--Very little room for improvement
4 Good--Little room for improvement
3 Satisfactory--Some room for improvement
2 Fair--Quite a bit of room for improvement
1 Poor--A great deal of room for improvement

a "6" for any item NOT APPLICABLE to your institution;
a "7" for DON'T KNOW;
or an "8" for DON'T UNDERSTAND the item

Treatment Program

1____
2____
3____
4____
5____
6____
7____
8____
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Community Interaction

31____
32____
33____
34____
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Evaluation Procedures

39____
40____
41____
42____
43____

Staff Development

44____
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Organizational Characteristics

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INSTITUTION SELF-STUDY QUESTIONNAIRE (ISSQ)

Treatment Program

1. Quality of intake procedures
2. Quality and frequency (optimally every six months) of diagnostic re-evaluations
3. Institution's policy and practices with regard to limiting its admissions to only those children it is able to serve in a constructive manner
4. Quality and effectiveness of treatment team meetings
5. Consistency of goals and methods among various work shifts, and effective ways to exchange and share information about the preceding shift's activities
6. Extent to which child has daily opportunities for affectionate care, gentle handling, play, and personal attention from direct care personnel
7. Use of constructive planned grouping rather than haphazard grouping of the children
8. Extent to which the staff focus and effort are directed toward equipping the child to return to the community when appropriate
9. Intelligent coordination of individual therapies, e.g., counseling, supportive psychotherapy, guidance and insight therapy, and group therapies, e.g., psychodrama, family therapy, and rap groups (if more than one form exist)
10. Extent to which diagnostic and treatment plans for the child and his family are evolved as a result of team efforts rather than as a result of individual professional decisions
11. Extent to which diagnosis includes assessment of family, community and agency resources along with the study of the individual child

12. Existence in written form of a realistic team "masterplan" for the study and treatment of the child (including specific goal-attainment planning) soon after his admission, with participation by the direct care staff, the child--and also by parents and referring agency if practicable

13. Sustained implementation of each child's "masterplan" and the programs designed to achieve the objectives of the plan

14. Periodic review (such as every three months) and reshaping of the child's "masterplan" during his residence, including invited input from the child when practicable

15. Training in reading skills

16. Training in number skills

17. Training in writing skills

18. Training in problem-solving skills, and self-directed programs of work or study

19. Efforts to provide a stimulating environment for the intellectual growth of the child, such as (where appropriate) open discussion of current events with the children, opportunity for participation in self-government, etc.

20. Training in age- and developmentally-appropriate interpersonal and social skills, and effective use of opportunities in institutional settings for applying these skills

21. Training in relevant recreational skills, and appropriate opportunities (play areas, gyms, toys, equipment) for stimulating and using these skills

22. Training in vocational and "home maintenance or fixit" skills which are integrated with the school program; and effective use of naturally occurring opportunities in the living setting to apply these skills

23. Training provided in sensori-motor skills, coordination, physical mobility and dexterity (when needed)

24. Training provided in language, speech development, and speech therapy (when appropriate)

25. Quality of medical services available to meet the children's needs

26. Extent to which child, his family, and the referring agency participates in discharge planning (when feasible)

27. Extent to which institution's total program is directed toward providing a home-like environment which attempts to normalize the child's experiences, and makes them parallel to the patterns of daily living in his community insofar as possible

28. Extent to which institution treats child as a human being, and protects and safeguards his individual rights in accordance with policies formally established by a Human Rights Committee

29. Inclusion of teachers, cottage parents, aides, and all direct care staff in developing an individual treatment plan for each child

30. Your opinion of the institution's overall effectiveness in providing adequate and appropriate services to children and their families

Community Interaction

31. Use by the children of community resources (e.g., churches, libraries, etc.)

32. Participation by the children in community activities outside the institution (e.g., Little League, bowling, etc.)

33. Institution's development and use of community resources, including volunteers and paraprofessionals, to supplement staff

34. Attempts made by the institution to disseminate information to the community about its philosophy, practices, and programs

35. Surrounding community's acceptance of the institution and its purposes

36. Extent to which institution acknowledges pressures for changes in policy or program from the outside community, and attempts to be thoughtfully responsive to them, rather than hostile or defensive

37. Extent to which the institution is going out into the community to provide education and preventative services, e.g., parent effectiveness training or mental health education

38. Adequacy of periodic feedback to and interaction with the referring agency with regard to the child's developmental progress

Procedures for Evaluating the Institution and Its Programs

39. Existence and accuracy of written records, such as logs or diaries, to describe what actually happens in the institution and its programs

40. Adequacy of documentation and evaluation of innovative practices within the institution

41. Systematic relevant evaluation of staff effectiveness by supervisors or peers or other appropriate persons, including the opportunity for participation by staff in their own evaluation, along with feedback to each employee regarding outcomes

42. Adequacy of feedback to staff, parents and (where feasible) each child concerning evidence of program effectiveness in terms of the degree to which individual objectives are met

43. Systematic and periodic followup of child after discharge

Staff Development

44. Quality of professional skills of the staff

45. Quality of staff training programs

46. Top man's encouragement of staff independence in operating matters

47. Opportunity given staff for discussion with appropriate persons in management regarding case handling, administrative matters, personal problems, etc.

48. Encouragement of staff growth and development through special opportunities such as in-service training programs, seminars, case reviews

49. Opportunity given staff to participate in important decision-making matters which affect them

50. Extent to which staff is given encouragement and recognition for the discovery, suggestion and implementation of innovative ideas

51. Program for orientation of the entire staff to the mission and programs of the institution, and means of program integration

52. Extent to which staff members are encouraged and helped to continue their education and upgrade their professional qualifications

53. Extent to which time and skills of professionals are appropriately utilized

54. Extent to which staff is trained and supported to effectively implement significant changes in program

Organizational Characteristics

55. Attempts made by the institution to learn about innovative promising child development practices or exemplary programs developed at other child care institutions

56. Judicious allocation of available financial resources for maintaining current programs

57. Degree of staff participation in budget preparation and implementation

58. Financial solvency--ability to operate within available financial resources

59. Dependability of immediate and long-range funding to permit effective planning

60. Top man's (executive director or administrator) identification with the program (i.e., enthusiasm, dedication and involvement with the program)

61. Degree to which staff is organized by child treatment programs, (i.e., into functional teams) rather than by professional groups, (e.g., social workers, psychologists, etc.)

62. Firmness and relevance of administrative control; and appropriate flexibility of administrative control to meet varied circumstances

63. Degree of productivity of staff meetings

64. Extent to which organizational climate of the institution supports open, easy, non-defensive communication flow among staff and with director

65. Clarity with which decision-making responsibility is delegated

66. Promptness with which administrative decisions are made known to all those affected by them

67. Extent to which the children can initiate or influence ideas for change

68. Regular cottage parents' satisfaction with competence and practices of night relief cottage staff

69. Freedom from internal pressures on staff to adhere to a particular theoretical position in treatment philosophy and practice

70. Extent to which administrative planning (selection of staff, grouping of children, development of services to the institution, etc.) is related to the treatment needs of the children

71. Degree of helpful interest, constructive concern and active participation by board (of directors) in policy formulation aimed at effective institutional performance

72. Staff compensation and fringe benefits compared with compensation and benefits in other approximately equivalent residential child care institutions

73. Suitability of physical plant to treatment program

74. Quality and sufficiency of food served

75. Explicitness of the institution's basic mission or purpose

76. Promptness or timeliness of the organization's response to significant identified problems of a child, or of institutional operations

77. Appropriate utilization of outside resources, such as consultants, to supplement or enrich staff capabilities for dealing with complex diagnostic or treatment problems or for organization development means

78. Existence of a research orientation in the institution's program, and the establishment of procedures whereby research proposals are regularly reviewed for their appropriateness and feasibility.

79. Degree of participation by the entire staff in planning of the goals, procedures and priorities of the institution

80. Your opinion of the institution as a place in which to work

A COMPENDIUM OF INNOVATIVE PRACTICES

Practices that Reportedly Work Well, Selected from Eleven Residential Child Care Institutions

Prepared by the
Human Interaction Research Institute

1972

APPENDIX C

A COMPENDIUM OF INNOVATIVE PRACTICES

Practices that Reportedly Work Well, Selected from Eleven Residential Child Care Institutions

n Research Institute

972

A COMPENDIUM OF INNOVATIVE PRACTICES

Item	Description	Sc
Student participation in a runaway situation.	In many institutions for children there are periodic runaways. In some institutions the students participate in a search for the runaway; when a hideout is detected, students are sent in to encourage the runaway's return to the institution.	Yo Po
Stand to talk.	In large meetings, it is established that the talker has the floor. In addition to standing to talk, the youngster is encouraged to walk around while addressing the audience.	Yo
Work for pay.	Many adolescents who have the ability may benefit by working at a regular job with regular hours and an opportunity for employment and advancement in the institution. One aspect of the philosophy is that clients may apply for jobs or specify jobs that need doing, establish pay rates through discussion, and thereby gain employment.	De Sa Bo Ch Yo
Funny Money.	One teacher requests the institution's print shop to print paper money in various denominations for use in the classroom. Funny money can be earned doing academic contract work and a list of available rewards for which it can be exchanged is made known to students.	So El

A COMPENDIUM OF INNOVATIVE PRACTICES

	Description	Source
tion in a n.	In many institutions for children there are periodic runaways. In some institutions the students participate in a search for the runaway; when a hideout is detected, students are sent in to encourage the runaway's return to the institution.	Youth Adventures, Portland, Oregon
	In large meetings, it is established that the talker has the floor. In addition to standing to talk, the youngster is encouraged to walk around while addressing the audience.	Youth Adventures
	Many adolescents who have the ability may benefit by working at a regular job with regular hours and an opportunity for employment and advancement in the institution. One aspect of the philosophy is that clients may apply for jobs or specify jobs that need doing, establish pay rates through discussion, and thereby gain employment.	Devereux Schools, Santa Barbara, California; Boys Republic, Chino, California; Youth Adventures
	One teacher requests the institution's print shop to print paper money in various denominations for use in the classroom. Funny money can be earned doing academic contract work and a list of available rewards for which it can be exchanged is made known to students.	Sonoma State Hospital, Eldridge, California

Item	Description	S
Early visit to town with other clients.	When possible, a newly admitted youth is sent with other youths to town to purchase what he will need for his stay. This visit and shopping expedition takes place early in the resident's stay, hopefully underscoring the facts that he will be active there, that other students will help him, and that the staff wish him to have ample necessary supplies.	B
Behavior checklist.	A checklist used weekly by ward workers charting specific items of a child's behavior. The items call attention to observable behavior and can be used as a method of documenting client progress.	N I
Community nursery school.	In operation within this institution is a nursery school open to children from the surrounding community, younger children within the institution and staff members' children. It provides child care pre-vocational work experiences for older adolescent residents and serves as one method of education and communication with the community.	D
High school students trained as baby sitters for retarded at home.	The parents of retarded children often have difficulty finding competent baby sitters. One institution solicited among high school students for trainees, established a training program for baby sitters for the retarded and can now provide a list of competent, trained sitters.	Ya
Documentation on film of patient's progress.	In some institutions, motion picture films of one child doing a series of specific motor acts may provide fuller documentation than scales for measuring motor skills.	Pa Po

	Description	Source
n with	When possible, a newly admitted youth is sent with other youths to town to purchase what he will need for his stay. This visit and shopping expedition takes place early in the resident's stay, hopefully underscoring the facts that he will be active there, that other students will help him, and that the staff wish him to have ample necessary supplies.	Boys Republic
st.	A checklist used weekly by ward workers charting specific items of a child's behavior. The items call attention to observable behavior and can be used as a method of documenting client progress.	Napa State Hospital, Imola, California
ry	In operation within this institution is a nursery school open to children from the surrounding community, younger children within the institution and staff members' children. It provides child care pre-vocational work experiences for older adolescent residents and serves as one method of education and communication with the community.	Devereux Schools
ents itters me.	The parents of retarded children often have difficulty finding competent baby sitters. One institution solicited among high school students for trainees, established a training program for baby sitters for the retarded and can now provide a list of competent, trained sitters.	Yakima Valley School
film of .	In some institutions, motion picture films of one child doing a series of specific motor acts may provide fuller documentation than scales for measuring motor skills.	Pacific State Hospital Pomona, California

Item	Description
"Train Your Own" needed staff members.	A well-rounded, practically and theoretically experienced child care specialist is very difficult to come by. One institution worked with a nearby college to devise a two-year training program yielding a Master's Degree plus a special teaching credential to students who possessed a Bachelor's Degree. The vast amount of training takes place on the hospital grounds in seminars and work experience. The curriculum is generally planned and taught by the staff. Graduates from this program are well suited for employment in a variety of child care settings, including this institution's "satellite homes."
Client goal setting.	Before and following admission to this institution the client sets his own goals. Questionnaires are circulated to applicants concerning their interests and self-analysis. Upon admission, discussion is made available to elicit personal characteristics the client feels a need to change and this list is amplified and clarified in discussion with the staff. From this discussion comes a set of goals often stated in behavioral terms toward which the institution and client agree to work.
Postcard follow-up of consultative services.	Six months following consultation services to members of the community this institution sends a two-part postal card requesting feedback on the interchange. By having standard questions such cards can be used systematically to collect data which has proven to be useful for the institution.

	Description	Source
bers.	A well-rounded, practically and theoretically experienced child care specialist is very difficult to come by. One institution worked with a nearby college to devise a two-year training program yielding a Master's Degree plus a special teaching credential to students who possessed a Bachelor's Degree. The vast amount of training takes place on the hospital grounds in seminars and work experience. The curriculum is generally planned and taught by the staff. Graduates from this program are well suited for employment in a variety of child care settings, including this institution's "satellite homes."	Children's Unit, Southside State Hospital,
ng.	Before and following admission to this institution the client sets his own goals. Questionnaires are circulated to applicants concerning their interests and self-analysis. Upon admission, discussion is made available to elicit personal characteristics the client feels a need to change and this list is amplified and clarified in discussion with the staff. From this discussion comes a set of goals often stated in behavioral terms toward which the institution and client agree to work.	David and Margaret Home La Verne, California
up of ices.	Six months following consultation services to members of the community this institution sends a two-part postal card requesting feedback on the interchange. By having standard questions such cards can be used systematically to collect data which has proven to be useful for the institution.	Napa State Hospital

Item	Description	S
Double identity.	Small teams are formed to organize an institution around treatment programs rather than professional categories. Each staff member occupies a team role as well as a professional role. Hopefully this double identity strengthens participation and interaction among team members and among professional colleagues.	S
Feedback on group interaction therapy.	In an institution which uses guided group interaction as a therapy method, trained observers visit each group, rate the depth of the interaction and provide this valuable feedback to the group leaders.	B
Monthly parent meeting.	This institution holds the monthly meeting of its parents' group on the institution grounds. The hospital director, staff and parents are urged and encouraged to attend. There is opportunity for interchange and first-hand information concerning the institution's needs and the available resources from parents.	P P
24 hour "live in."	This is a community education project plan in which a number of citizens from the community are invited to "live in" the institution for a 24-hour period, accompanying residents in their activities. The "live in" becomes part of an ongoing process of orientation/education of the community to the institution.	Y

	Description	Source
	Small teams are formed to organize an institution around treatment programs rather than professional categories. Each staff member occupies a team role as well as a professional role. Hopefully this double identity strengthens participation and interaction among team members and among professional colleagues.	Sonoma State Hospital
inter-	In an institution which uses guided group interaction as a therapy method, trained observers visit each group, rate the depth of the interaction and provide this valuable feedback to the group leaders.	Boys Republic
eting.	This institution holds the monthly meeting of its parents' group on the institution grounds. The hospital director, staff and parents are urged and encouraged to attend. There is opportunity for interchange and first-hand information concerning the institution's needs and the available resources from parents.	Porterville State Hospital Porterville, California
	This is a community education project plan in which a number of citizens from the community are invited to "live in" the institution for a 24-hour period, accompanying residents in their activities. The "live in" becomes part of an ongoing process of orientation/education of the community to the institution.	Yakima Valley School

Item	Description	So
Co-planning by institution.	Special services are often expensive and difficult to come by. In this instance, the institution and the local school system carefully plan together to avoid duplication of services. There is direct interchange of students, some coming from the local school to the institution school and vice versa.	Ya
Day placement of immobile patients.	For enriched stimulation of bedridden children this institution places them on mats near the activity during the day, diminishing the isolation that can occur.	Ya
Use of films and slides.	In this institution for training young retardates many procedures are specific and systematic. One way to convey these procedures to less experienced staff members is to make motion picture films or slides showing the particular sequence.	Pa
Cosmetologist.	This institution employs a full-time cosmetologist to assist the girls (and some of the boys) in grooming and self-care, enhancing their self-image. Such staff positions are not traditional but some regular availability of these services seems cherished by the residents.	Ca Di Ta
Toughening.	Toughening is a method of staff intervention in which a client is encouraged to participate in an event, generally of a physical exercise nature. With group participation urging people into the action, the fearful person hopefully gains in self-esteem and confidence.	You

	Description	Source
titution.	Special services are often expensive and difficult to come by. In this instance, the institution and the local school system carefully plan together to avoid duplication of services. There is direct interchange of students, some coming from the local school to the institution school and vice versa.	Yakima Valley School
mmobile	For enriched stimulation of bedridden children this institution places them on mats near the activity during the day, diminishing the isolation that can occur.	Yakima Valley School
lides.	In this institution for training young retardates many procedures are specific and systematic. One way to convey these procedures to less experienced staff members is to make motion picture films or slides showing the particular sequence.	Pacific State Hospital
	This institution employs a full-time cosmetologist to assist the girls (and some of the boys) in grooming and self-care, enhancing their self-image. Such staff positions are not traditional but some regular availability of these services seems cherished by the residents.	Cascadia Juvenile Reception-Diagnostic Center, Tacoma, Washington
	Toughening is a method of staff intervention in which a client is encouraged to participate in an event, generally of a physical exercise nature. With group participation urging people into the action, the fearful person hopefully gains in self-esteem and confidence.	Youth Adventures

Item	Description
Refinement of existing development scales.	Gesell, Goddard, Ross, Cain, Levine and a number of others have developed observational scales intending to show the ordinary course and sequence of the development of motor, language and cognitive skills. Such devices seem better suited for assessment or survey instruments, rather than as measurement of client progress within a training program. Work is underway, however, to revise these scales into smaller "step-levels" amplifying the skills under description and training and locating the sequence through observation.
Movies for public education.	The institution leaders think through several important institutional features and solicit professional motion picture or television producers to consider making a documentary film. These films are available to the institution as well as to the producer.
Foster grandparents.	Placement of certain retarded children is often made difficult by the absence of adequate foster homes. This institution encourages older persons in the community to become volunteers in the institution. Some of these foster grandparents have become genuine foster parents.
Individualized daily schedules.	Hour-by-hour individualized program for each resident is composed each day, printed in quantity, and made available to persons who have contact with that client, especially the person in charge of his overall daily program.

	Description	Source
isting les.	Gesell, Goddard, Ross, Cain, Levine and a number of others have developed observational scales intending to show the ordinary course and sequence of the development of motor, language and cognitive skills. Such devices seem better suited for assessment or survey instruments, rather than as measurement of client progress within a training program. Work is underway, however, to revise these scales into smaller "step-levels" amplifying the skills under description and training and locating the sequence through observation.	Sonoma State Hospital, Porterville State Hospital, Southside State Hospital
	The institution leaders think through several important institutional features and solicit professional motion picture or television producers to consider making a documentary film. These films are available to the institution as well as to the producer.	Southside State Hospital
ts.	Placement of certain retarded children is often made difficult by the absence of adequate foster homes. This institution encourages older persons in the community to become volunteers in the institution. Some of these foster grandparents have become genuine foster parents.	Yakima Valley School
lly	Hour-by-hour individualized program for each resident is composed each day, printed in quantity, and made available to persons who have contact with that client, especially the person in charge of his overall daily program.	Yakima Valley School Devereux Schools

ORGANIZING TO PROVIDE INDIVIDUALIZED SERVICES IN CHILDREN'S RESIDENTIAL CENTERS

A Guide for Institutional Directors

Harvey L. Ross, PhD
Jean Hall, MSW

Final Report (Section B) to
Office of Child Development
Department of Health, Education and Welfare

Project Grant No. OCD-CB-103
October, 1974

Human Interaction Research Institute
10889 Wilshire Boulevard
Los Angeles, California 90024

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Preface

This document is a product of a grant awarded by the Office of Child Development (OCD) to the Human Interaction Research Institute (HIRI) in mid-1971. Because the project's history has been complicated--as is often the case with exploratory investigations that break new ground--many different individuals and groups became actively (if sometimes temporarily) involved during its several stages. A history of the project's first year--a year essentially spent in exploration and experiment, trying to clarify and to get a handle on the problem--is recorded in the project's Final Report to the Office of Child Development: Facilitation of Knowledge Utilization by Institutions for Child Development, Grant No. OCD-CB-103, October, 1974. During the first year, David Berger, Harold Boverman, Bernice Eiduson, Edward Glaser, Andrew Morrison and Harvey Ross visited a dozen children's institutions in California, Oregon and Washington, to study their innovative practices and the circumstances associated with their adoption. This preliminary activity provided the basis for the work plan that was adopted the second project year. Edward M. Glaser, the project director of record, took responsibility for the project's leadership during this year.

In this preface, we focus on the project's second and third years.

During the second year, the project carried out a systematic field investigation. Toward the end of the first project year, Harvey Ross proposed to OCD that part of the project's final report be prepared in the form of materials that might be useful to institution directors, consultants, and others who are concerned with helping children's residential centers improve their services to children. Duane Ragan of OCD endorsed that initiative and, with Maiso Bryant (who became our project officer) has provided helpful support during the development of this document.

At the beginning of the second project year, HIRI adopted an investigative strategy based on providing organizational consultation to four children's residential centers. The project engaged Robert Blinkenberg and Thomas Hallam (both doctoral candidates at the U.C.L.A. Graduate School of Management), Andrew Morrison (a practicing psychologist) and Jean Hall (a social worker with considerable experience in children's agencies) to provide that consultation. Harvey Ross (the project's principal investigator) both worked as a consultant to one institution and assumed leadership responsibility for the field effort. This group became the project team. Its members shared responsibility for planning, information collection, and analysis. Molly Lewin, the project's editorial consultant, and Devon Chappel, Lynnette Robe, and Dolores Gregory (who successively served as project research associates) met with the team, regularly. During the phase of active consultation, Bernice Eiduson and Howard Boverman helpfully participated as consultants to the consultants.

The project team held (approximately) half-day meetings with more-or-less bi-weekly frequency during the active consultation phase (August, 1972 to June, 1973). The team met several times thereafter to review their experiences in the institutions and to develop possibly generalizable formulations about those experiences. During the post-consultation phase, each team member also contributed narrative accounts summarizing his consultation strategies and activities and wrote about special topics which the group felt were especially meaningful and in which he was particularly interested. This document draws heavily on the team's creative efforts; wherever possible, attributions are made to team members who were responsible for the work on which the particular discussion is based. During the second year, Edward Glaser developed the Institutional Self-Study Questionnaire which appears in the appendix of this document; David Berger assumed responsibility for the statistical and EDP analysis of the data generated while the questionnaire was being tried out. During this year, Edward Glaser also attended team meetings on occasion, and read consultants' reports of their consultation experiences, often providing feedback via marginal comments.

During the second project year, the team engaged in fieldwork at four children's residential centers. Our use of examples and anecedotal material drawn from those centers has regretfully made it necessary to preserve the annonymity of those institutions in this document. We would have preferred to be able to give directors and staff members the very great credit they deserve for their openness in inviting us into their institutions, taking us into their confidence and permitting us to participate in meetings and in other ways to share in the life of the settings. Without their voluntary participation there could not have been a project of this kind.

Of the four agencies, three were private and were members of the California Association of Children's Residential Centers. We thank the (then) executive secretary of that organization, Joseph Thesing; its presidents during the second and third project years, James Mann and Hans Cohn; and the membership for supporting our efforts by opening their meetings to us and providing insights about the context in which CRCs have been operating in California.

During the third and last project year, the authors analyzed the information that was collected in the field and prepared during the second year and wrote drafts of this document. A number of interested individuals--most of whom are professionals associated with the operation of children's residential centers--reviewed the final draft: Dave Berger, Sam Berman, Maiso Bryant, Dean Conklin, Robin Gegauff, George Horne, Dorothy Kirby, Edwin Millard, Katheryn Nielsen, Garrett O'Connor, Sam Ostroff, Art Tantardino, and Carlo Weber. We appreciate their generosity in giving many helpful suggestions. Because of time constraints derived from our agreement with OCD, we unfortunately could not utilize all of their suggestions, as we would have liked. However, since we intend to continue work in human service-providing agencies after the expiration of this OCD grant, in order to prepare a further enriched and rewritten version of this product for re-publication and more general distribution in the future, we plan then to take their suggestions into account. Although their contributions have already helped us immensely, we of course in no way mean to imply their endorsement of our work. The authors, alone, take responsibility.

Finally, we salute Molly Lewin, our lucid, determined and resourceful editor, and Marian Hunt, our indomitable research associate and project secretary, for their contribution in producing this document.

HLR

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I. Introduction

During the last decade, children's residential centers (CRCs)* have increasingly been confronting external pressures both from funding sources and from the consumers of their services. The former group (elected officials, legislators, administrators of funding agencies), sensitive to the increasing cost of maintaining children in 24-hour care, have been pressing for fewer referrals, shorter stays, and alternative placement within communities with resultant lower costs. The latter group (parents, referring agencies and other special interest groups concerned with providing quality services to children) have been pressing for improved treatment programs and better residential services--both of which often mean increasing cost per unit of time spent in an institution.

Both groups are concerned with and demand more accountability. Funding sources are increasingly concerned with issues of cost effectiveness--with what they are getting for their investment. In a recent informal survey, a number of private, nonprofit children's residential centers in California stated that they now are being asked to be explicit about the services they provide, what they achieve by providing those services, and what are the related costs. The state legislature has been bringing similar pressures to bear on public institutions for almost a decade. Consumer groups want systematic evidence that children are being helped by residential programs. Expressing this point of view, Leopold and Shein (1973, pp. 209-210) argue against continued support for social service programs that fail to sustain a minimal commitment to program accountability. They express the belief that governmental and/or consumer influences will be increasingly exerted in purchase of service contracts.

Within institutions, boards of trustees, directors and staff are concerned with improving services: to serve as many as possible of those children whom they should serve; to provide effective services; whenever possible, to keep them in residential care only as long as is necessary. Reducing the length of time children spend in institutions minimizes risks that they will become adapted to an institutional society and thus incapacitated for life in the community.

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* For purposes of this discussion--and, indeed, in the rest of our presentation--we do not differentiate between public and private agencies, except where explicitly indicated in the discussion. The organizational issues and pressures we are discussing appear similar for both kinds of agencies. "CRC," "agency" and "institution" are used interchangeably.

Although improved and more intensive residential treatment costs more over a shorter period of time, reducing the length of stay associated with increasing effectiveness usually brings down the total career cost per child, which means a better cost/benefit ratio. For example, one institution markedly increased the cost per unit of time spent by a child in the agency by doubling its staff to improve services. Their career cost per child dropped, however, because of the marked decrease in the amount of time it was necessary for children to spend in residential care.

Improving institutional competence to provide effective treatment involves:

1. Internally, improved program efficiency and effectiveness, which usually is associated with individualization of treatment.

2. Externally, improved linkage between the CRC and the community, to facilitate both movement into and out of the institution as needed, and also continuing treatment in the community as necessary. Improving linkages also should improve the agency's responsiveness to changes in external conditions and expectations, that is, increasing the institution's adaptability.

Both require the ability to change--to adapt the best practices of the best children's residential centers and to plan and implement creative improvements as they are developed by an institution's staff.

> The message of history clearly indicates that what is avant-garde in treatment technology today will quickly become passé. Thus child care institutions--in fact all children's services--should be organized to permit the infusion of new modes of treatment and care as well as the evaluation of old ones. However, this seemingly simplistic goal becomes extremely difficult to implement. Institutions often become wedded exclusively to one technology. This implies that all children in an institution can be treated or cared for within the framework of a single technology--a logic that appears to disregard developmental and/or functional differences. (Whittaker, 1972b, p. 55)

Being able to change, in turn, and in large part depends upon characteristics of an institution's organization.

Background for the Study

In the spring of 1971, the Office of Child Development (OCD) funded a three-year project proposed by the Human Interaction Research Institute (HIRI) to study the process of innovation and change in children's residential centers. HIRI's intention was to learn about how CRCs could adopt or adapt innovative practices to improve their programs. OCD planned to use our findings to promote the utilization of beneficial practices and research findings by children's institutions throughout the country.

During exploratory visits to more than a dozen institutions, it became clear that change and innovation would not take place simply as a result of informing institutions about desirable practices--not even if we were to employ special dissemination techniques.

Many of the institutions we visited had a history of resistance to change; some had managed to change, but only as a result of intense external pressures and at the cost of considerable trauma. Institutional readiness to make changes appeared to spring from organizational characteristics that were beyond the influence of dissemination efforts. Management style, the distribution of authority and responsibility, the distribution of roles and relationships among staff members, and organizational willingness and ability to review performance in relation to purpose all seemed involved, but it was not apparent in what ways.

Accordingly, HIRI adopted a project strategy that used organizational consultation, as a participant-observation technique, to enable both further exploration to identify organizational conditions related to an agency's ability to make beneficial changes and also the development of methods of intervention to create these conditions. Neither the literature nor our prior experience identified, satisfactorily, organizational variables associated with change phenomena that would have enabled us to conduct a systematic, controlled study of such factors. Our effort, then, had to be exploratory and investigative. Participant-observation is well suited to that purpose: It placed our project staff on the inside of children's institutions and permitted them to observe a wide variety of phenomena that appeared related to the institutions' ability to make desirable changes.

Between August 1972 and July 1973, each of four HIRI teams spent up to 40 days in one of four selected CRCs in the Southern California area.

The Institution

The four institutions were selected because of the diversity among them. Three were privately operated CRCs and one was a children's unit in a publicly supported state hospital. One of the institutions was considered to have an exemplary, sophisticated treatment program; another was regarded to be in deep trouble, in large part because of its recent attempts to make important changes over a brief period of time. The other two institutions were viewed somewhere between these two extremes on a scale of sophistication and effectiveness. Following are brief descriptions of the institutions (fictitious names are used for each):

A. The Lakecrest Children's Home Residential Center

This center has been in operation since 1889. Its focus has changed through the years from the care of neglected children at its inception to its present mission of the care and treatment of emotionally disturbed children. The home is a nonprofit, nonsectarian organization, licensed by the California State Department of Mental Hygiene and operated by the Lakecrest Children's Home Association. The governing board of trustees consists of 21 members. The annual budget for the agency is approximately $1,166,000.

The agency provides residential care for boys and girls aged 6 to 11, group home (community treatment) care for boys aged 12 to 15 and girls aged 12 to 17. It serves a total population of approximately 45 children who are referred by such agencies as the Welfare Department and the Probation Department, by relatives, private psychiatrists, school personnel, child guidance clinics, etc.

The treatment operation is based on the team, comprised of unit supervisors, unit coordinators, child development counselors and social workers. Teachers and tutors from the on-grounds school are also part of the team.

Lakecrest generally was considered one of the most sophisticated and best organized children's institutions in the state.

B. The Red Rock Children's Residential Center

This center was founded 60 years ago as an orphanage and has evolved quickly over the past 10 years to become a residential treatment center for children. The home is a nonprofit, nonsectarian organization operated by a Protestant church organization. Its board of directors consists of 24 members. The annual budget for the agency is approximately $500,000.

who have no overt physical or mental disabilities. Many of the children come from unfortunate home environments, and have developed emotional and behavioral characteristics which have led to their rejection by the natural family, foster families, and public schools. Average census is 37 children in four cottages on the agency's main campus, six boys in a prototype satellite home in a nearby community, and six girls in a recently opened, similar satellite home. Children are accepted through county and private placement.

The task of Red Rock is to provide the personal, social, and educational development necessary for the child to return to a family environment. The staff also works to prepare the environment into which the child will go, by providing therapeutic services to parents, by developing foster parents, or by seeking adoptive families for the children. Although most of the children attend local public schools, special educational programs on campus provide intensive help for those who cannot yet succeed in the public school program.

C. The Children's Unit of Southside State Hospital

This unit provides residential psychiatric hospital services to boys and girls, aged 4 to 16.

Begun in 1950, the Children's Treatment Unit has always been part of the larger Southside State Hospital which was opened in 1937 but at the time of consultation, the unit in many ways had remarkable autonomy, isolation, and relatively little interaction with the larger hospital.

In 1972 there were approximately 160 patients in residence, cared for by a staff of approximately the same size.

As with most other state hospitals, in earlier years various subsections had been headed by physicians or psychiatrists, but such leadership has changed in the last few years. Since 1952 the unit had been headed by a child psychiatrist with an essentially psychoanalytic orientation. In 1972 the Children's Unit was divided into eight separate subprograms, each program with a specified population, therapeutic aim, and general therapeutic modality. A program coordinator headed each treatment program; in August of 1972, three were led by physicians and five by psychologists. In addition, a special school for patients offered the services of a principal, some 22 teachers and a speech therapy department. The staff of the Children's Unit, consisted of some 160 persons representing age groups in their 20s, 30s and 40s, with a number of persons aged 60 or more occupying higher level positions.

The Children's Unit has initiated an innovative program to train college students to become professional child care specialists. Approximately 25 students commit themselves to a 2-year program designed to award them a master's degree and a teaching credential, both granted by a local college. The program consists of a full-time work experience with clinical exposure to mentally ill children, under the guidance of a skilled professional person, plus approximately 10 hours of classroom work, seminars, and discussion.

Upon completion of training, these students are placed in satellite homes (two in each home) where they act as foster parents for mentally disturbed children within communities near their parental home. Two of the four satellite homes are located on Southside grounds. Such homes provide a more normal setting for the children and can be maintained at a cost per child which is approximately one-third of what it is in the State Hospital.

D. Valleyview Boys Center

This is a children's residential center housing approximately 80 educationally handicapped and emotionally and behaviorally disturbed boys between ages 11-15. It is located in a rural setting. The facility consists of four cottages (of two units each) which are several hundred yards away and quite isolated from an administration building, an on-campus school and a refectory. Most of the institution's operating costs are borne by the public agencies (primarily county welfare and probation departments) which refer the children. In addition, there is considerable financial dependence on the diocese in which it is located, which not only sponsors the agency, and makes up deficits in operating costs, but also pays off a mortgage on the approximately five-million dollar property. The architectural design of the buildings and their setting are unusually attractive for an institution of this kind.

Valleyview began about 80 years ago as an Indian school. For the last few years it has attempted to make rapid changes from an orphanage (staffed primarily by a religious order) to a modern residential treatment center (staffed by a treatment-oriented lay staff). These efforts toward change have had a very unstabilizing effect on the organization. The staff was unusually heterogeneous with regard to experience, competence and child care philosophies. They had difficulty in working together in a coordinated manner for the benefit of the children. Indeed, staff conflict absorbed a considerable amount of their attention and energy.

The director--who had been appointed a little more than a year before the consultants began their work in the institution--wanted to close the institution in order to make a fresh start with a new staff. He had been refused permission to do so largely because it was financially unfeasible. This institution already has been characterized as being "in deep trouble."

At the time of consultation, all four institutions had a residential facility that was both the institution's main campus and the site of its administrative offices. Although some of the agencies were developing satellite facilities--primarily, group homes--the consultation almost exclusively dealt with organizational issues on the main campus. However, because our discussion deals in part with organizational decentralization, it will also likely have some relevance for agencies which are structurally decentralized into separate facilities and services.

The Study Process

During the course of the consultation program, and after, the consultants aimed toward developing some common frame of reference that would permit a comparison of their experiences: to identify the significant issues with which each CRC was concerned and engaged; to test and clarify their formulations; and then to combine and present them in terms that would be meaningful for institution directors, staff members, consultants and other audiences of their findings.

Even though consultation took place at only four institutions, the variability among their sophistication, organizational proficiency, and willingness to engage in consultation, and the intensity of contact (35-40 visits each during the year) provided a unique opportunity to study their organizations, in relation to their ability to provide services. Children's residential centers frequently utilize consultants who are mental health consultants focusing on case consultation or staff development. In contrast, consultants who focus on organizational issues are rare in agencies that provide human services. Learning about the issues that are discussed in this document was possible only because the grant afforded us an extraordinary opportunity to provide intensive organizational consultation.

Soon after beginning the consultation, we realized that a CRC's ability to make desirable changes was related to its general organizational competence. In order to be able to change, it needed internal capability for self-assessment through which it could identify those areas in which changes were needed, for planning and for implementing new practices. The ability to make desirable changes is only one manifestation of general organizational proficiency. We concluded that we could neither study a CRC's ability to make changes nor provide consultation focused on helping it to do so if we ignored organizational issues which were general and comprehensive throughout the institution.

In this manner, our consultation focus expanded to a broad perspective on the organizational characteristics of the four institutions. The consultation afforded us a window on organizational issues in children's residential centers that appear to have generic significance: These issues were important not only in our small sample of four institutions but might also have relevance for many agencies that deliver human services. This document presents what we believe are generalizable formulations about the organizational issues that managers might fruitfully ponder when assessing their agency's ability to provide effective services.

Although we discuss organizational issues that appear to have general importance to the health of an institution, we do so primarily when issues bear upon an agency's ability to provide individualized treatment services. By individualization we mean tailoring services in accordance with a specific plan designed to address special needs of an individual child. Individualization refers to the way in which decisions are made, not to the modality used; an individualized plan may include a group treatment modality. We are not suggesting that institutions should move in that direction. The mission of any given institution depends on community expectations--its social function--and the availability of resources to provide expensive or professionally demanding services. However, all four institutions in which we worked were in various stages of trying to provide such services and were making efforts to improve their ability to do so. Therefore, our discussion of organizational issues in this document will tend to have that orientation.

Early in the project, we were most aware of differences among the institutions: in their formal and informal organizations, treatment technologies, staff sophistication, and organizational issues with which they appeared to be contending. Later in the project, and especially as we reviewed the considerable body of information we had amassed, important similarities began to emerge, apparently stemming from attempts by all four institutions to improve the effectiveness of their treatment by attempting to increase the degree to which their treatment of children was individualized. Although in that regard they were at different stages of evolution, all had implemented or were contemplating some form of organizational decentralization as a strategy to permit greater individualization of decision making. Most had organized or were considering organizing their staffs into treatment teams.

In effect, then, a major part of all the consultants' activities became engaged with one or another aspect of these changes. In retrospect, we can roughly classify most consultant activities into two categories: those designed primarily to help implement organizational decentralization and team functioning; and those aimed primarily at repairing certain organizational difficulties apparently created by efforts to decentralize.

The Study's Findings

The purpose of this document is to present what we have learned about the organization of children's institutions in the course of our consultation activities. First, we will focus on the nature of organizational decentralization and team functioning in children's residential centers. We did not systematically study these issues as part of our project (they only emerged as issues after our project was well underway) so our presentation of this material in large part will depend upon information from the literature. Second, we will identify a number of organizational difficulties attendant upon decentralization and describe ways in which agency management can attempt to deal with these problems. This latter discussion will primarily be based upon the experience of the consultants in the four institutions.

Although our concepts were developed in the course of consultation, we do not discuss the process of consultation itself. Rather, we are presenting what we learned about the organization of children's institutions in the course of those interventions, our many team discussions, and our subsequent exploration of the literature about organizational theory and children's institutions.

Because there is no comprehensive literature about organizational issues as they relate to children's residential centers, we have had few precedents to guide our presentation. We regard our efforts as an early and exploratory attempt to identify some of the apparently significant organizational issues that might usefully be considered by those who are concerned with children's residential centers. Thus, our formulations are not meant to be prescriptive. Rather, they are meant to stimulate consideration and reflection.

We have chosen to use a number of theoretical formulations--particularly those of open systems theory--to organize our discussion. However, we do not intend to present or substantiate a theory as much as to use theory to tie together observations, impressions and inferences about relationships between the organization of children's residential centers and their abilities to provide services.

While providing consultation, we became aware that a number of organizational characteristics of institutions appear related to their mission--in particular, the kinds of services they provide: Institutions that provide basic child care services (nurturing, custodial) tend to have their own organizational characteristics and institutions that provide treatment services within a traditional context of basic child care services have organizational characteristics that are, in turn, different from institutions that provide individualized treatment services. This observation comes as no surprise. Any institution needs to organize its staff in special ways to carry out those tasks that enable it to achieve its mission. In an effective organization, mission determines structure.

The ability of an agency to provide individualized treatment services in part depends upon the locus of decision making about children's needs. Appendix C summarizes some of our formulations about structure in relation to the centralization/decentralization of decision making. It lists schematically some important organizational characteristics that apparently are concommitants of the centralization-decentralization continuum. The Appendix may be useful to the reader in two ways. First, the reader can compare and contrast organizational characteristics of institutions that offer individualized treatment services with those that do not. Second, the reader may be able to identify organizational characteristics requiring change if the institution intends to move from relatively non-individualized to relatively individualized services (or vice versa) and which needs a developmental sequence for its organization.

The first five chapters of this document discuss the decentralization of decision making as an organizational strategy that permits individualization of services, and the possible use of interdisciplinary treatment teams, as one way to integrate the efforts of a service-delivering staff. Chapter VI lists a number of organizational difficulties that result from decentralization. The remaining chapters describe some new roles for management in a decentralized institution, especially in relation to overcoming the organizational disadvantages of decentralization.

II. Organizing to Individualize Treatment: The Decentralization of Decision Making

The preceding chapter reviewed the impact of changing public policy and community expectations on the mission of many CRCs. This new mandate emphasizes intervening to bring about enough improvement in deviant children so that they can be returned to their communities as quickly as possible. Today, professional opinion holds that intensive, individualized care is the most effective kind of intervention. From an organizational standpoint, the key question now is: Which organizational and management strategies will most enhance an institution's ability to treat children as individuals?

A key element clearly is how decisions are made in an institution. Individualization means that an institution is able to make decisions about a child in accordance with his idiosyncratic characteristics and needs. So, an institution's ability to treat individuals in accordance with their special needs depends upon its ability to individualize decision making.

An institution fulfills its mission by carrying out one or more primary tasks, such as: child care; education; work (farming or forestry, for example); treatment. Primary tasks have been defined in contemporary organization theory as "all tasks that are essential for survival, however many, and whatever their priority." (Rice, 1963, p. 185) Depending upon its mission, a CRC naturally undertakes one or more primary tasks. Each primary task may require a relatively independent set of operations, each of which involves its own decision-making pattern. An institution's overall organizational design is created to enable decision making to be made in a manner that is appropriate to the work required to carry out the operations that help it achieve its goals.

Traditional organizations--variously called "hierarchical," "centralized," or "bureaucratic"--tend to make decisions centrally. Most of the organization's decision-making prerogative is vested in its administrators, executives and managers, many of whom are far removed from work sites. Decisions may range widely--from organizational policies to the way in which work is carried out. Although managers are far removed from work sites, they decide for operational personnel which tasks they are to perform, how they are to organize themselves and how they are to do the work.

In recent years, many kinds of organizations have been experimenting with decentralized decision making, which distributes these prerogatives throughout an organization. In a decentralized organization, those who have most information about an issue generally make decisions about it. Thus, operating personnel make many decisions about how they are going to do their work; managers decide about such things as the internal distribution of resources and relationships with consumers. Typically, organizations employ decentralized decision making when work involves educational, creative and problem-solving activities; for example, research and development, artistic enterprises, and a department, institute and school organization within a university.*

CRCs decentralize decision making in order to permit child-caring staff members to make decisions about children on an individualized basis. This section discusses decision making as a basic institutional characteristic--in particular, the kind of decision making that is thought to be best suited to the primary task of providing individualized care. There are a number of reasons why decentralization may provide the best organizational conditions for carrying out individualized treatment.

A. Decentralized Decision Making Permits Flexibility in Dealing with Deviance

Children are referred to CRCs because their deviance from behavioral norms is too great for them to be served or tolerated in their homes and other community settings. Most of such settings--schools, churches, local businesses, law enforcement agencies--are not sufficiently malleable to individualize their services beyond a limited range, nor are they intended to be able to do so.

Their flexibility is limited in large part by their centralized organization, as previously described. They provide relatively standardized and routine services according to policies and decisions made centrally and relatively remotely from the site where services are provided. Even though an individual employee might want to provide an individualized service to a child, a centralized organization tends to divide up work and responsibilities in a fragmented way so that no one person can vary his segment of a standard procedure to fit some exceptional circumstance without causing dislocation in the organization. When a child's behavior or his needs are idiosyncratic, he is referred elsewhere for care and services--often to a CRC.

Some CRCs attempt to individualize their services to meet the needs of these children. For individualization to occur, a CRC must be able to vary its services in relation to complex, changeable, unpredictable and uncertain circumstances (Litwak & Rothman, 1971, p. 65).

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*More recently, industry has been experimenting with decentralized decision making to better accommodate both employees' social and psychological needs and the technology of industrial production (sociotechnical systems).

To be appropriate for the individual, decision making must be flexible. Those responsible for providing a service should be able to take into account the idiosyncracies of those they serve and be free to make relevant decisions with a minimum of constraint. A considerable body of literature documents the difficulties experienced by centralized children's institutions when they try to establish treatment programs and individualize services (Zald, 1960, pp. 57-67; Polsky & Claster, 1970, pp. 86-109).

Flexibility is, of course, limited by the realities of social and institutional constraints. Policies and procedures vital to the institution's survival and the willingness of staff and children to put up with the deviant behavior of any one child constrain the possibilities of making any decision on a completely individualized basis. However, under circumstances of decentralization, such constraints are minimized to provide the greatest possible flexibility.

B. Decentralization Permits Institutional Staff to Adapt a Proactive Stance to Plan to Minimize Crises

In many CRCs, especially those in which decision making is centralized, staff members typically spend a good deal of their time attempting to cope with crises. If individuals or groups of children misbehave or get into difficulties, the staff reacts by trying to help resolve the problem and restore tranquility. When staff members are reacting to events--dealing with them after they have occurred--they sometimes think of their jobs as "putting out fires." In some agencies, "fire fighting" seems to be the principal mode of operation. Planning to avoid crises with particular children and particular groups of children cannot readily be done anywhere but at the level of child care because the kind of information that is necessary for such planning exists only at the child care level. When staff functions are defined in terms of implementing decisions and policies made centrally and when they are not encouraged or permitted to make many inventive decisions at the level of child care, they usually have a reactive stance. When child care staff has the authority to make decisions, and when they are trained and expected to use that prerogative, they can plan to avoid crises. That is, they can adopt a proactive stance.

Although the following example is taken from the operation of a maintenance staff observed by one of our consultants, it illustrates some of the differences between reactive and proactive stance:

> In one agency, its maintenance staff never seemed able to catch up with their work orders. They always were behind. Their method of operation was reactive: They spent their

> time *responding* to requests for services, scheduling their activities to fit the priorities of others. If they had had a proactive stance, they would have *planned* a maintenance program which might have prevented many requests for services and which probably would have enabled them to avoid having to schedule their activities in a disjointed and inefficient manner.

Whenever child care staff is not given authority to make the decisions necessary to deal with child care issues, problems likely will be referred up the supervisory-administrative ladder for solution. When supervisors, professional and administrative staff try to deal with problems that have occurred remotely from them and about which they have a minimum of information, they may propose inappropriate solutions that are not likely to be implemented by cottage staff.

> In one institution, child care staff referred crises (about children) at the unit level to (geographically remote) professionals for resolution. Lacking sufficient information, the professionals often were unable to produce solutions appropriate or acceptable to child care staff. At times, problems ultimately landed in the lap of the director, who felt obligated to make *some* decision--which staff often interpreted as arbitrary. Professional and administrative personnel spent a large proportion of their time *reacting* to such crises.
>
> The HIRI consultant pointed out that the professional and administrative staff were preoccupied with such crises--and that their efforts, in too many instances, were fruitless. Institutional administration subsequently informed unit staff that they were expected to deal with the immediate problems of children as they occurred, as best they could. Professional and administrative staff found they had more time available for planning and other activities which seemed to them to be a much better investment of their time.

C. Decentralization Is Conducive to Learning from Experience How to Improve Institutional Effectiveness

Learning to improve in large part depends upon the availability of information about the consequences of one's efforts. If decisions are made centrally, remote from the living unit and child care sites at which they will be implemented, those who make the decisions likely will have access to only limited or even distorted information about consequences. With inadequate feedback information, the decision makers are not able to correct for error or to know how to improve.

Decentralizing combines doing and planning in the same staff members. This combination places staff in a position to improve their effectiveness.

* * *

Decentralization imposes important new demands on institutional staff members, especially those at the child care level: To use their new responsibility and authority effectively, they need to develop more expertise than is necessary in traditional, centralized agencies. Decentralization also provides new challenges to managers: they may no longer make certain decisions, but they retain responsibility for seeing to it that those decisions are being made and that their consequences support and are consistent with organizational goals. Thus, each time managers delegate authority, they need to agree with staff about appropriate indices of accountability. Further, because managers' control through supervision is weakened, and because units and individuals have greater autonomy, they need to learn new management techniques to integrate organizational effort. Subsequent chapters will deal with these issues.

Our discussion of decentralization has been about where decisions about child care and treatment are made. Decentralization is an organizational strategy and does not in itself denote any particular organizational structure to implement it. How decentralization is implemented depends upon the nature of the staff to which managers delegate the authority to make decisions: its composition; its competence; the scope of its authority and responsibility; the definition of the relationships between individuals within a decision-making group.

In the following chapter, we describe one model that is being used in a number of ways in various institutions with which we had contact: the treatment team. We describe the team model in general terms, and illustrate our discussion with examples of some possible variations.

III. The Treatment Team: One Model for Implementing Decentralization

A. What Is It?

A treatment team is composed of all members of a CRC staff who are directly responsible for and concerned with the progress of an individual child. In general, a team's membership contains combinations of the following: child care worker(s), social worker(s), other professionals (a physician, psychiatrist or psychologist), a teacher (if there is an on-campus school), and, at times, the child, his parents (or parental surrogates), placement workers, representatives of referring agencies, etc. The treatment team is described by Maier (1965, p. 663) as providing treatment that:

> ...is structured to enhance the therapeutic experience of each client, each staff member adding his competence on the basis of each client's needs for it.... Staff functions are defined by a combination of professional preparation and the demands of the situation. The essence of team work is less a delineation of functions than a constant adaptation of boundaries between staff roles and integration of several professional functions into one... the child care worker becomes the pivotal treatment agent.

The group need not have permanent boundaries or leadership; it may change in relation to shifting emphases and responsibilities. The particular composition suggested here is neither inevitable nor preferred.

A team meets to share information, to set treatment goals and plan methods, to evaluate progress and plan post-discharge placement; in brief, to chart, organize and monitor a child's career through an institution and his way out of it.

Although many operational responsibilities are shared, some specified person must accept responsibility for seeing to it that necessary tasks are carried out and for satisfying the accountability requirements that accompany delegation. A person need not himself perform every activity for which he is responsible and accountable. Team leadership responsibilities--for scheduling meetings, for keeping records, for seeing that necessary decisions are made and responsibilities for implementing those decisions fulfilled, for assessing team performance and for the team's accountability to institutional management--may be distributed among team members or may be assigned to a unit manager who becomes a team member.

The treatment professional (psychologist, psychiatrist or social worker) contributes special expertise to help the team diagnose children, to identify goals appropriate to their needs and developmental stage, to develop treatment techniques to help them progress toward those goals and to assess that progress. The professional likely also has consultation skills that enable him to train other team members to employ treatment techniques. The professional usually assumes leadership in finding or developing with other staff members new techniques to fit particular needs of individual children. Although professionals may continue to provide direct treatment services to children, their impact is maximized if they train child care staff to provide such services.

The child care worker provides the team with his intimate knowledge of individual children, derived from prolonged daily contact with them. In addition, the child care worker contributes his experience and skills in dealing with individual children in group care and his ability to form meaningful relationships with them. Armed with treatment methods learned from the professionals, the child care worker can become a main purveyor of treatment. Although all forms of the treatment team require that child care workers participate as members and manage a child care process that supports treatment goals, the extent to which the child care worker assumes primary responsibility for treatment appears to depend upon his ability to carry out that responsibility (derived from training and experience) and the willingness of professionals to relinquish their traditional role as therapist in favor of becoming resource persons and consultants.

This study makes no claim regarding the most appropriate role for child care workers. Deciding what is best in terms of what is most effective for children is itself a subject for investigation, experimentation, and demonstration. Our aim here is to describe at least some characteristics of that role as they have been presented in the literature and as we have observed them in our four institutions.

Other team members--teachers, parents, professionals from other agencies--all have special knowledge and skill to contribute to the team effort. The child himself can be a particularly important member. If he has participated with the rest of the team in developing goals that are meaningful to him and that he has subscribed to, the child will be likely to guarantee his own motivation and commitment to the treatment process.

Teams often base their activities with children on an educational or developmental model. The team regards a child's everyday behavior both as expressing the child's needs for help and as providing opportunities for identifying his strengths and for intervening to support development. In institutions for the mentally retarded, for example, a team may undertake to identify a child's developmental status in order to create ways of helping the child learn new skills and advance on the developmental continuum. In institutions for the emotionally, behaviorally, or mentally disturbed, a team may try to help a child learn new behaviors to replace maladaptive behaviors. Inasmuch as a team's own processes are based on a learning model, those processes are consistent with and supportive of its activities with children.

The concept of "team" is one of people of different disciplines and different skills working together in a carefully thought out and planned way to provide optimal care for the child and his family. Its members' roles are not clearly delineated at times, and may overlap with each other. This does not eliminate or reduce the necessity of accountability, but enables team members to share responsibility for treatment effectiveness rather than its being the sole responsibility of one person.

A treatment team takes a form and performs functions in relation to characteristics of the particular institution in which it is embedded: its mission, primary task and technology; its traditional staff functions and staff relationships; its ability to decentralize decision making; its ability to change.

Here are some examples of treatment teams, as they have been organized in three CRCs. They are described in ideal form, as they are intended to function.

1. A large state hospital for the mentally retarded (not one of our four institutions) decentralized its hierarchical organization into a dozen "programs," each of which provides specified kinds of services suitable for a particular patient population

   Internally, each program is divided into treatment teams, made up of psychiatric aides, their supervisors and medical and other specialists. Each team is responsible for planning and conducting individualized treatment programs for particular patients.

   Each program director is directly accountable to the hospital superintendent and to representatives of referring agencies for the effectiveness of the treatment of individual patients assigned to his program. Similarly, each team leader is accountable to the program director for the progress of each patient toward the goals set for that patient.

Teams operate by identifying explicit proximal and long-range goals appropriate to the developmental status of each patient. Then, professional staff specialists (physicians, psychiatrists, psychologists, teachers, nurses) teach the psychiatric aides (the main purveyors of primary care) particular treatment methods that are likely to help each of their patients learn the new skills implied by his treatment goals. When they do not already know effective methods, the professional staff is responsible for learning or developing new ones.

2. At a small, church-supported institution, the team has developed an organization appropriate to that particular facility.

Team Members

The core of the treatment team is at least two child care workers, a unit supervisor, a social worker and a child of a unit. During placement, the team may also include the child's parents, the placement worker, the director of cottage life and for consultation purposes only, the psychiatric consultant and agency administrator.

Team Meetings

The purposes of the treatment team meeting are the formulation of long-term and short-term treatment goals and the review of those goals to insure that the treatment plan is current and relevant to the child's needs. Each member of the treatment team has the opportunity to contribute to the development of treatment goals. Although no one is designated as team leader, the social worker often takes responsibility for structuring the meetings and does have specific responsibility for recording the goals developed by the team members.

The weekly review of the child's degree of goal accomplishment is the team's evaluative component. By use of a daily log in which the child care workers and unit supervisors record the behavior of the children in the unit, progress or lack of progress toward the stated goals is evaluated. Responsibility for the progress of the child belongs to the team; however, the social worker in collaboration with the team can make judgments about the child's development which lead to the transfer of the child to the agency group home or another appropriate setting.

Regular meetings between the assistant director, the director of treatment services (chief social worker) and the director of cottage life also serve an evaluative function. Through their inputs which represent administration, social services and the units, there is an attempt to insure the effective coordination of services and monitor the consistency of treatment for each child in placement.

Roles of Team Members

Unit Supervisor--As a part of the child care staff, the unit supervisor is responsible for the care and treatment of the children in his unit. As a supervisor, he is responsible for the training and supervision of the unit child care staff. Both are accomplished during his daily interaction with the staff while they perform their child-caring and treatment tasks. Entries in the daily log also provide the supervisor with material for instruction. Additionally, workshops designed by the agency staff (e.g., how to develop and implement more effective goal plans) are periodically available to the supervisor and the staff for development.

Child Care Workers--The child care workers are responsible for the implementation of the treatment goals in the child's daily living situation. Through consistent interaction directly with children, they are also responsible for recording information in their respective unit's daily log which relates to the treatment of the children in the unit.

Social Worker--The social worker has the responsibility for providing the team with assessments of the child's family situation and for recording treatment plans as they are developed by the team in the treatment meetings. The social worker also keeps placement agencies informed about their children's progress in treatment.

The Director of Cottage Life--The training of the unit supervisors and the monitoring of the child care standards of each cottage are the responsibility of the director of cottage life, who provides feedback to the supervisors through discussion. There is also an informal monitoring of the child care standards of each unit which insures that each cottage has the material and staff resources to provide quality child care.

3. Another private residential facility uses a different design for its treatment team.

Team Members

In daily operations, the team is made up of specific child care staff who interact with the child in the unit, the unit supervisor, unit coordinator, social worker, teacher and other important persons which may include the child himself, his parents, and volunteers. For planning and decision making, the medical director and nurse join the team.

Team Meetings

The purposes of the treatment team meetings are the development and review of the treatment plans for each child in the unit. Although the unit supervisor is the chairman of the meeting, each team member has equal opportunity to participate in the development of the plan. During the meeting, treatment goals are formulated, methods for achieving the goals are outlined, staff responsibilities which relate to the achievement of the goals are assigned, and indicators which mark the achievement of the goals are described.

The review and evaluation of the treatment plans are accomplished by means of a goal-tracking system. Each goal, when developed, is assigned a weight from 1 to 4 which indicates "the degree of difficulty to achieve" for a particular child. Based on the indicators described in the treatment plan, the team determines whether the goal was achieved or to what degree it was achieved, assigning an achievement rating from 1 to 8 (achievement is 8). Goals are recorded and progress or lack of progress is charted. The team is accountable to the associate director for the progress of the children in their unit. The goal-tracking system gives the associate director a clear picture of the goals achieved, not achieved, and their significance for the child's development.

Roles of Team Members

Unit Supervisor--Treatment leadership is the major task of the unit supervisor. This involves facilitating the staff's development and implementation of unified treatment plans for both individual children in the unit and the group as a whole. Teaching, leading, coordinating, and interacting with his staff on the unit are the means by which the unit supervisor achieves unified treatment approaches.

His responsibilities also include assuring that open and honest communication patterns prevail within the unit. To reach this goal, the unit supervisor has at his discretion various supervisory techniques including individual, group, and total staff conferences to promote individual development and to build positive working relationships among staff.

Child Care Worker--The responsibility for insuring that the routine daily living needs of the child are met is that of the child care worker. Within the context of the group living situation, the child care worker is also responsible for a part of the treatment plan which has been developed and is carried out in collaboration with other treatment team members.

Social Worker--The social worker has the responsibility for contributing to both the diagnostic assessment of the family and child and actively participating in the treatment plans regarding the family. He is usually the primary therapist for the family and he may also involve the child care staff in this treatment process. Being physically located in the unit, the social worker becomes quite involved in the daily milieu of the child. Additionally, he is responsible for recording the treatment plan developed by the team.

Unit Coordinator--The unit coordinator has the responsibility for the coordination of specific aspects of treatment services such as staff scheduling, the unit medical program, recreational activities, etc. He also chairs treatment team meetings in the absence of the unit supervisor.

Medical Director--Treatment direction is the overall responsibility of the medical director. He reviews and signs each treatment plan developed by the treatment team, to insure that the child is being given proper psychiatric and medical attention. He has the power to approve the plan or request that a new plan be developed.

B. Special Advantages of the Treatment Team Organization

The treatment team model embodies a number of organizational characteristics that theoretically should support an institution's efforts to individualize treatment. This section lists a number of such advantages.

1. Organizing staff into treatment teams locates decision making about children at the level of child care, where a maximum of information is available and where the participation of child care staff increases the likelihood of their implementing the decisions that are made.

Because everyone having significant contact with each child can be present or represented at team meetings, the participants have available a maximum amount of information about each child.

It is the availability of such information that enables decisions to be individualized. Furthermore, the participation of staff members who will implement the decisions promotes their commitment to those decisions.

2. A treatment team organization enables an institution to combine the expertise of its staff members.

Working as a team is particularly important for the staff members of a children's residential center because, "No existing profession has by theory or training any decisive leadership or total competence to fulfill the primary task." (Child Welfare League, 1972, chap. VI) In a treatment team the traditional roles of staff members blur and change and no longer are predictable from professional identification. Child care workers develop treatment skills and become more "professional" and professionals become more involved in the child care process. A team organization makes it possible to coordinate the contribution of each staff member to the treatment process.

3. A team organization concentrates staff resources at the child care level--in the core of treatment.

The institution deploys its treatment resources--professionals, most staff with specialized functions (recreation, teaching, medical) and outside consultants--to living units where, in the team model, the treatment activities take place. By doing so, the institution focuses staff attention at the level of child care, defines their responsibility for helping to create and support a therapeutic child care process, and signifies that its priority concern is its children and that the child care process is the vehicle for treatment.

When professionals and other special staff are attached to an institution's administrative level, and especially if they are housed in offices that geographically are part of the administration's offices, they may tend to work primarily as resources to the administration and can so become identified in the minds of children and child care staff. Designing the organization so that they work and are located within living units where they will be available to child care workers and children, makes it clear that they are employed primarily to support the delivery of treatment services.

4. A treatment team can learn from its own experiences to improve its own effectiveness.

Organizing into teams provides opportunities for engaging in the processes of discussion, exploration, experimentation, and negotiation, all of which are ways that enable a work group to learn. A problem-solving posture enables a work group to address the great variety of individual needs that characterize deviant children and that need to be dealt with whenever treatment is individualized.

> The rationale of teams in their various forms and settings is to produce outputs (decisions and/or operations) better in quality than that of its single individual members. The maximum utilization of these teams would be achieved through a way of operation which would permit the fullest use of the unique contribution of each profession on the team. A relatively free interplay of the professions and respect for the value and indispensability of each member profession would facilitate contributions drawing on the intrinsic potentialities of the professions concerned. (Cohn, 1971, p. 39)

A treatment team can work as a learning unit, by performing its primary task (treatment), by evaluating the effectiveness of its efforts, and then by using that information to learn to improve its methods in order to be more effective. An organizational design that concentrates the needed information, expertise, decision-making authority and operational responsibility in the same work group enables the treatment team to work as a learning unit. By way of contrast, if these functions were distributed among "departments," each of which carried on its own activities in relative isolation from the others, the responsibility to learn likely would be too diffuse to serve as motivation and the conditions of learning--contingent upon bringing together the above component requirements--would be hard to establish.

5. A treatment team defines staff roles and relationships in a manner that is consistent with the humanistic values of treatment,

Because the team process involves shared responsibility and is collaborative and egalitarian, it encourages positive interpersonal relationships among team members and minimizes non-work-related competition, etc.

Individual members tend to be respected for their contribution to the team effort. Competence, expertise, and achievement are valued over non-performance-related characteristics, such as organizational and professional status. The most influential member of the team, at any moment, likely will be the person who is most competent in relation to the matters being addressed. Leadership may pass easily from a teacher to a child care worker, to a child, to a professional, then to the child's parents. Because a team's efforts benefit from a variety of skills and points of view, each member can become a resource and can be recognized and rewarded for his contribution.

Since most staff members, regardless of professional group membership, are assigned to work in living units, barriers based on separation due to organizational structure, profession, or status tend to dissolve. Frequent formal meetings and informal discussion increase mutual understanding. Although team members likely will have differences of opinion, some of which may not be resolvable, they will be in the open. The openness and frequency of interchange should minimize the mistrust and paranoia (the attribution of hostile intentions) that typically develop when there is interdependence without frequent communication or accessibility.

A well designed treatment team encourages the personal development of each of its members. Individuals' activities are minimally constricted by set procedures and restrictions associated with professional group membership. Each team member can contribute whatever he is able to the group effort. Recognition by the team serves as an incentive to develop new skills. If the team fosters personal growth and positive personal relationships and embodies values that are intrinsic to treatment, it can itself serve as a model to the staff and children in a CRC.

6. Organizing its treatment staff into teams permits a CRC to organize its administrative and treatment processes in different ways that are consistent with the requirements of each.

Institutional administration requires routine procedures that are orderly, stable and consistent in relation to the environment and to its own operating personnel. Routine tasks usually are best carried out by a traditional organization that has explicit rules and defines specific duties to be carried out by people and machines with specialized skills. Characteristically, there is separation between those making policy and those implementing it.

> On the other hand, individualizing treatment precludes routinization. Activities cannot be specified in advance, nor can there be rules detailing all aspects of the job. Instead, decisions need to be made by those implementing the treatment, guided by their internalized understanding of institutional mission and general policy. (Litwak & Rothman, 1971, p. 65) The team organization permits its treatment staff sufficient flexibility and discretion to carry out individualized child care while enabling the institution's administrative level to be organized in whatever manner best facilitates the orderly conduct of business. The institution is free to establish whatever balance is needed between routinization and flexibility. (Clark, 1969, p. 282)

Decentralizing decision making and organizing staff into treatment teams can overcome *organizational* barriers to individualizing treatment. However, agencies do not all have the capability to function effectively in a team organization. Doing so requires special resources, particularly a staff that is able to play the required roles. The following chapters describe the model in greater detail, to enable the reader to understand its requirements and to assess its relative advantages and disadvantages.

IV. New Staff Roles in an Interdisciplinary Team

This chapter discusses, in some detail, staff roles in a team organization, primarily as they are described in the literature, with special emphasis on needed skills, team relationships, training requirements and possible staff resistance to being organized into teams.

A. The New Role of the Child Care Worker

As a purveyor of treatment services, the child care worker combines new responsibilities for treatment with his traditional responsibilities for child care. He babysits less and intervenes more. Because decentralization means less external guidance from supervisors and gives greater discretionary authority to the child care worker, he needs more internalized guidance to help him exercise his independent judgment. At the least, he needs to internalize institutional values associated with its mission and to learn new skills that enable him to understand the behavior of children so that he can intervene to encourage their development and socialization and to modify their non-adaptive behavior.

This section first depicts some of the requirements of the job of a child care worker who has responsibilities for intervening to achieve treatment goals; and second, describes how working as a member of a team can provide him with support and training to help him do that job.

1. The child care worker's role in treatment

The role of the child care worker as a treatment figure was first conceived over 30 years ago. Bettelheim, Redl and others created a decentralized organizational model--the life space model--as a context for the individualized treatment of children in "milieu therapy." In the life space model, the focus is not on the individual psychotherapy session, but on the child's own natural life space milieu. A greater responsibility for treatment resides with the child care workers who are closest of all to the child for the longest periods of time and who, therefore, often can have the most profound impact on him.

> ...the child care worker becomes the life space therapist. All of the human and physical resources of the residential treatment center are ordered in such a way to produce a truly therapeutic environment, which is both the primary means of treatment, as well as the context within which it takes place. (Whittaker, 1972a, p. 103)

Although the life space model and milieu therapy have been much admired and their terminology has been absorbed into the rhetoric of child care, they have not been widely utilized. They require a degree of child care staff sophistication that is difficult to achieve without a Redl or a Bettelheim who could recruit talented and highly motivated child care workers and provide them extraordinary training on-the-job. Some recent descriptions of the role of the life space therapist depict the high requirements the job imposes on child care workers.

> The milieu worker, to develop fully the curriculum of living, must pursue two parallel modes of operation. These we call capitalizing on what happens and designing the environment.
>
> In the first, capitalizing on what happens, the worker reacts to clues, germs of ideas, and indications of tension that emerge in conversation, in sounds, through observations of everything from individual moods to the weather. These may indicate need for enriching the cirriculum (for example, pull the group together for a snack). There may be indications of interest that can be developed from group discussion (for example, planning a trip to the beach). There may be new entry points discernible for individual work to be done. Everything that happens, however, is a significant part of the curriculum of the group's living and presents to the worker the possibility for capitalizing on it.
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> In the second dimension the worker "proacts"; he purposefully plans specific activities or events to achieve desired goals. He anticipates the needs of the group and designs programs to meet those needs...Itchy, annoying, irritating behavior needs to be elevated into a hike or a chinning contest, more than it needs to be squashed so the group can get back to "normal." Proactive planning would recognize that there are times of the day and year when kids are "antsy." Activity and structure would be designed by the worker in recognition of youngsters' needs during those times. Thus, the effective milieu worker must be both proactive and reactive in his work with children...
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> Return of the group to "normal"...is not the goal; neither is having everything a beautiful success the goal of curriculum. Rather it is the creation of the fabric that has interest, fun, new experiences, new ways of solving problems that will help kids to raise their consciousness of what happens, why, what can happen, and what they can do about it.

> The children shift from recipients to participants. The worker shifts from controller to facilitator. (Barnes & Kelman, 1974, pp. 20-21)

In his daily interactions with children, the child care worker needs to be able to resolve apparently conflicting expectations: the administrator's need for system maintenance and the child's need for individualization.

> The professional task in the group living situation is to find the viable and operational connections between the institution's needs for a "tight ship" and the client's needs to develop autonomy and negotiate within and among the various systems with which he must come to terms. As the worker finds these connections, his job increasingly becomes one of performing both instrumental and expressive tasks, of maintaining the tight ship and individualizing, as he goes about working with the children within the organizational structure and auspices. This is a difficult task and one that the worker never quite feels that he has mastered; but it is the road along which lies the development of real professional skill and identity. (Birnbach, 1971, p. 181; 1973, p. 96)

It is clear that the child care worker who has treatment responsibilities needs special training to prepare him for the job.

> Milieu therapy is not simply bringing a variety of specialists into a place where kids live. It is not simply living where you get treated. In spite of all of the specialists who deal with separate phenomena of a child's life, we do not have a therapeutic milieu for children. We can have nothing more than a matrix of professionals until we can clearly perceive a professional role that has the capability of integrating a child's total experience in residence--his specialized treatment requirements with his normative requirements for social, educational, work, and recreational experiences. This discipline must also be a specialist one, unique, however, in that it makes the general a specialty. Its practitioners must be able to digest a social history, analyze finds of psychological testing and psychiatric evaluation, assess the capacities of the residential program, and synthesize all of their data into a working knowledge of the child, his needs and how they can be met.

> Clearly a worker of this caliber is not just a nice widow who has raised her own kids, and had a course in psychiatric information or some in-service training. Nor is it a turned-on college dropout who has been in three encounter sessions and is now supervised by an ACSW. He is a fully trained professional and nothing else. He must be trained for the job. (Barnes & Kelman, 1974, p. 12)

An institution should not assume that a child care worker can step into the complex role described above and do that job without training.

> For too long we have labored under a false illusion that the child care job should be performed by so-called "naturals" who possess a superhuman combination of personal attributes. Child care will stand alongside other helping disciplines as an equal partner only as it is able to demonstrate how it uses specific skills to achieve clearly defined helping tasks. (Birnbach, 1973, p. 96)

In many European countries, child care is recognized as a professional speciality on a par with other human service specialties. As a professional, the child care worker has primary responsibility for the institutionalized child and a wide purview of authority. He often has received professional training in institutions of higher education, may be certificated, is well paid, and has access to job ladders that lead to the position of institution administrator. (Hromadka, 1964, p. 297)

In the United States, however, child care is not yet fully recognized as profession, and most agencies likely are reluctant to delegate as much authority and responsibility to him as is done in Europe. The educational opportunities that exist in Europe are rare in the United States; most training traditionally has been done on-the-job-or in-service. Although some educational institutions now offer some training, practicum training on-the-job will always be an important component.

The treatment team can be a powerful resource to the child care worker, because it makes available opportunities for support and training to help him fill his complex role and develop professional competence.

2. How the team supports and trains the child care worker

A treatment team usually is empowered to make a wide variety of decisions and recommendations concerning a child:

admitting the child into a living unit; diagnosing his treatment needs; setting proximal and distal treatment goals; identifying behavioral criteria against which progress can be judged; planning a therapy strategy; defining the child's freedom and the constraints upon it; assessing readiness for placement back in the community; and working with families.

As the one who knows the child best, spends the most time with him, may have the most meaningful relationship with him and therefore the most impact, the child care worker can make important contributions to the team effort by:

a. Providing information to other team members.

b. Participating in making decisions with and about the child.

In return, the team supports the work of the child care worker in a number of ways:

a. By defining treatment goals for individual children that are explicit, concrete, progressive, and divided into manageable steps.

b. By developing a treatment strategy and methods for implementing it. To maximize their teachability, techniques of interventions should be described in behavioral terms.

c. By stipulating criteria that the child care worker can use to judge his progress. Knowing the signposts of progress can be a source of encouragement when they are being passed or a sign that he needs more help if they are not.

By working with the treatment team in this manner, a child care worker should be able to learn intervention techniques that constitute his developing professional competence. Working with the treatment team enables the child care worker to become a major figure in the treatment process...the most important process in the institution...thereby enhancing his status and opportunities for advancement. The team helps him develop professional skills and gain recognition for his attainments with children.

It is very likely that all of the expertise needed to help train child care workers will not be available on the staff of any institution. First, since an institution's professional staff may never have worked in a team organization, they may not, themselves, be very knowledgeable about the training needs of a child care worker who assumes a treatment role. Second, an institution may want to adapt new methods and techniques developed elsewhere. Learning to improve staff and program effectiveness on a continuing basis may best be done by the judicious employment of outside expert consultants. Later in this presentation, a section will discuss the use of outside resources in a staff training and development program.

B. The New Role of the Professional

In many institutions, reorganizing into teams means replacing a medical model of service delivery with a developmental model. In the medical model (for example, the hospital model), the professional usually does not participate in life in the living units. He is an "outsider." Although he is a member of an institution's staff, he may be part-time. Usually, he and other professionals are organized into a department or service; they work in offices contiguous to one another, but at a distance from living units. In a children's institution, when social workers are first hired, they typically manage interface (casework) functions: intake, family counseling, placement. They do not work with or in close proximity to unit staff. In a traditional institution, the professional, by virtue of his training and credentials has the sole responsibility for making therapeutic interventions. The function of child care staff is to maintain the child between his treatment hours.

Ideally, when the professional becomes a member of the treatment team, he moves from being an outsider to being an insider; and from being the sole purveyor of treatment and specialized services toward being a consultant to others who provide those services.*

1. His primary group membership changes.

He moves from a professional department to a living unit where he becomes a member of an interdisciplinary work group. Working in the unit, he has access to as much information as possible about each child, has the greatest possible number of opportunities for discussion with his colleagues on the team and shares decision-making authority with them.

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*The extent to which he shifts roles in fact appears to depend upon a number of complex considerations, including the competence of child care staff in a particular setting and the willingness of professionals and administrators to redefine roles.

2. As a member of a team, the professional's authority likely depends more on his competence (what he can contribute) than on his status.

3. To some extent, the professional's function becomes "de-specialized." The child care worker shares his traditional responsibility as purveyor of direct treatment services. In turn, the professional shares the child care worker's traditional responsibility for the day-to-day condition of the child.

4. The professional's main responsibility shifts from providing direct services toward supporting others--primarily the child care worker--in providing those services.

5. Because he is more in touch with the everyday problems of the living unit and has accepted more responsibility for the child (rather than only for providing treatment), the professional is likely to be more pragmatic in his work. He may be more inclined to accept ways of helping children and solving problems on the basis of their usefulness, rather than on their theoretical purity.

C. From Supervisor to Treatment Team Leader

If traditional supervisory practices are permitted to persist, they can subvert the successful operation of teams. In traditional institutions, supervision typically is carried out within role groups--the specialities or departments. The total child care process is divided up into purviews of activity customarily assigned each role group. The focus of the supervisor who belongs to one of the role groups is on monitoring the activities that are carried out by the staff members within that role group. Because no one group or staff member has total responsibility for the progress of a child, supervision typically tends to focus on the activities claimed by a role group--and sometimes on the accounting of activities--rather than on the child. Thus, social work supervisors tend to monitor case work or treatment activities; the school principal supervises teaching activities; the supervising child care worker is concerned with how cottage personnel carry out their child care routines; etc.

Decentralization to a team organization brings about a considerable change in traditional hierarchical relationships. In a CRC, those relationships are formalized by supervisory relationships. Insofar as an important function of supervision is to insure that decisions made centrally are carried out at all levels of the organization, the decentralization of a significant portion of the decision-making process deprives traditional supervisory relationships of their function and thus makes them superfluous. Interdisciplinary teams plan and implement strategies to deal with the needs of individual children.

Hromadka (1972, pp. 298-300) reports his impressions of the work of such teams in European settings. When professionals and well-trained child care workers work as an interdisciplinary team, he observes less preoccupation with professional status and (apparent) need for supervision in our sense, and more staff homogeneity, mutual respect and shared learning between team members of greater and lesser experience and with different professional identities.

At the child care level, the worker moves away from following routine procedures towards flexibility and discretion. Child care staff are expected to follow their own judgment, experience and internalized sense of institutional values and mission in applying interventions developed by the team. Although some general policies and rules continue to be formulated centrally, they are minimal and do not determine the thrust of individualized treatment. They may need to be taken into account, and may constrain treatment (because preservation of the institution is a value that overrides treatment considerations for any individual child), but the judgment of how they are applied is made by the team, rather than by a supervisor. In this manner, the team process under appropriate leadership tends to assume the supervision of staff behaviors and procedures.

The team leader's primary functions are managerial and facilitative--creating circumstances that permit other team members to do their work. The management functions include coordinating meetings to support the forward movement of treatment: goal setting, treatment planning, treatment review and evaluation of treatment.

In team meetings, the team leader may be chairman. He may take responsibility for agendas (soliciting items from team members) and for seeing that minutes are kept. However, unlike a supervisor, he does not use meetings to instruct staff, or to have them report to him. He does not direct discussion; he facilitates it in order to encourage each team member to make whatever contribution he can to the team process. The benefits of such leadership are suggested by an interesting anecdote from an article by John Matsushima.

> In a traditionally organized institution in which child care staff was resistant to the prescriptions of professional staff, one supervisor experimentally desisted from instructing child care workers about how to deal with a chronically provocative child. Instead, he "moved into the role of discussion leader rather than outside authority. He encouraged them to call on their own impressions and experience, and he urged their joint efforts toward an acceptable solution." The group of child care workers made some decisions about managing the child that resulted in significant improvement "...and it seemed that success resulted just as much from the cottage parents' favorable response to the decision-making process as from the decision per se." (1964, p. 294)

Managing the interface between the team and its environment is one important function of the team leader. This responsibility may include:

Coordinating the team's work with other teams and other living units.

Coordinating the team's work with other work groups that have responsibility for components of the primary task: institutional intake, placement in the community, and follow-up.

Coordinating the team's work with children's parents and other outsiders who participate on the team.

Satisfying the team's need for outside resources: for staff training and development and for special services.

Providing accountability information to institutional management --primarily about progress or lack of it with individual children.

A team leader may take responsibility for other activities that support the team's operations as a learning system (for which someone must take responsibility). He may see to it that regular assessments of a child's progress are made, that the child is followed up after placement and that the information about the child's progress (and the team's effectiveness) is made available to the team. When evaluation leads to the identification of needs for improved staff skills, the treatment leader may assume responsibility for identifying and making available appropriate resource persons who can conduct staff training and development. If the leader himself has special expertise, by virtue of his experience and training, he can himself become a resource to the team. These new functions are a far cry from the traditional functions of supervision.

D. Staff Resistance to the Treatment Team Organization

Changing from a traditional organization to a decentralized treatment team organization involves significant changes in staff roles and relationships. Staffs understandably are likely to resist radical changes.* They usually have considerable investment in the way things always have been and resist disturbing traditions with which they are comfortable and in which they likely have come to believe.

A first sign of staff resistance may be a change in the language they use as they talk about their jobs but without corresponding signs of efforts to change job behavior. Rewards and punishments become "positive" and "negative reinforcement"; misbehavior is called "acting out"; and reprimands become "counseling." Even the appearance of treatment teams on organizational charts may not mean that a change has occurred in the delivery of treatment services. Those teams can meet and discuss children and make decisions without in fact doing the careful diagnosis, individual goal setting and planning for progress that individualized treatment requires.

Institutional management has an important role in attempting to avoid such resistance, by recognizing it and attempting to remedy it when it does occur.

In our experience, staff resistance is rooted in the following kinds of issues:

1. Convictions about their institution's proper mission

   Staff members of custodial and traditional child care institutions once selected themselves for those particular jobs. They likely believed, or have come to believe, in those kinds of missions and in the ideologies from which those missions stemmed--that it is proper (for example) that the institution should induce conformity and punish or eject children who disturb its tranquility. Such beliefs often are rooted in personal child-rearing ideologies that cannot easily be changed by administrative directives.

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* or to misinterpret their scope and purpose. In some agencies, staffs have interpreted efforts to decentralize to teams as an invitation to abandon all managerial controls and have resisted accepting responsibility for accountability procedures.

2. Uneasiness among child care workers about the increasing influence professionals and other "outsiders" may have in the child care process.

In traditional institutions, the child care worker, despite his relatively low status, effectively has control over the most important process in the institution: the ongoing relationship between the child and the institution. When supervisors are stationed within living units and have the same ever-present and continuing relationship with the children and child care workers, they share that same control. Introducing "outsiders" (professionals, parents, others) raises fears that their effective authority and control will be diminished.

3. Uneasiness among professionals about the requirements that they become more involved with unit life.

They may be reluctant to move into the "inside" of an institution. They may feel uncomfortable with groups of children and, perhaps, with child care workers. Unless they have had special training--for example, as group workers--they may not have had experience working with children in groups. They may feel uneasy about being called upon to do that with which they are unfamiliar and to achieve more than they are able. Whatever their performance and their achievements, they may be afraid that their mistakes will be exposed. Because many institutions have not structurally provided for adequate offices in living units, the resulting discomfort and inconvenience may reinforce the resistance of professionals to working in units. (It may in fact be impossible for them to do certain tasks without having private, quiet offices available.)

4. The change in mental set that is required by decentralization of decision making.

Participating as a member of a team means a major change in authority relationships--from following instructions and standardized procedures to participating as an equal with professionals and supervisors in discussion and in making decisions.

5. Accepting increased responsibility for outcomes with individual children.

Traditional institutions usually divide up the total task of child care so that no one individual has responsibility for the child. Rather, individual staff members have responsibility for their part of the child care process. Each person's responsibilities tend to be defined in terms of how well he performs the function that is his part of the process. In a treatment team, everyone shares the responsibility for the progress of the individual child, at least to some extent, even though one person may accept overall responsibility for each child. The increase in responsibility and accountability can be disturbing and can be a source of reluctance to change.

6. Involving children and parents as participants in decision making.

Both in custodial and in traditional treatment institutions, staff members make decisions about clients. They may have an investment in maintaining this prerogative. They do not easily accept the participation of children and their parents in decision making with the team.

Fairweather (1973, p. 25) notes the resistance of professionals to "diminishing (their) supervisory behaviors" that may be required by some innovations in the field of mental health treatment. The resistance is so great that even when the innovation is "accompanied by a dramatic reduction in cost and an increase in effectiveness, (it) appears to prevent the acceptance of this new treatment innovation."

These difficulties attendant on changing staff roles have familiar precedents in other kinds of agencies that provide human services. Maxwell Jones describes numbers of problems related to decentralizing authority in mental hospitals that have their analogs in the experiences of children's residential centers. Among them were the assignment of professional personnel to units and difficulties staff members had in developing new roles and role relationships both in relation to other staff members and to patients.

> A therapeutic community (is) distinct from other comparable treatment centers in the way the institution's total resources, both staff and patients, are subconsciously pooled in furthering treatment. This implies, above all, a change in the usual status of patients. In collaboration with the staff, they now become active participants in the therapy of themselves and other patients and of other aspects of the overall hospital work--in contrast to their relatively passive, recipient role in conventional treatment regimes. (1962, p. 53)

V. Organizing Into Teams to Resolve Problems Inherent in Traditionally Organized Treatment Institutions

This chapter will discuss some difficulties inherent in the traditional organizational model of children's treatment institutions, and will suggest how organizing into treatment teams can help to remedy those difficulties. By the traditional organizational model we mean the organization of an institution's staff into parallel departments or services each one of which consists of an occupational or professional group that is responsible for its own set of activities, such as: the child care staff, social service staff, school staff, etc.

The traditional organizational model developed when treatment services were introduced into children's institutions that historically provided basic child care and custodial services. At that time, it was generally believed to be the best way to accommodate both the treatment and child care primary tasks. The literature contains many references to this attempt at accommodation. Among the most detailed is the account of the history of Hawthorne's experience in implementing the new philosophy. (Alt, 1960, chap. 5) However, the experience of many institutions suggests that the traditional model has inherent characteristics that tend to generate typical problems.

This chapter describes a number of specific problems associated with the traditional organizational structure and indicates how the treatment team model can help to mitigate them.

A. Characteristic Problem Areas in the Traditional Treatment Organization

This section focuses on a number of problems inherent in the traditional organization, particularly as they have ramifications for staff relations and operations.

1. Difficulties Stemming from Hierarchical Structure

In traditionally organized treatment institutions, staff members are grouped by professional and functional role groups into departments. Thus, the organization creates homogeneous disciplinary groups that tend to emphasize status differentiations, especially between treatment and child care staff, but even between the professions. Typically, for example, social workers accept a subordinate role vis-à-vis psychiatrists; psychologists may not. (For a more thorough discussion of this phenomenon, as it involves social workers, see Cohn, 1971, p. 39.)

In the traditional organization, the child care worker generally is assigned a restricted role and accorded a low status. Adler (1971, p. 210) states, "There is a tendency in residential treatment settings to perpetuate a class structure among staff with professional clinicians stressing the superiority of their knowledge and leadership, and child care staff delegated to secondary status."

The traditional role has been characterized by Barnes and Kelman in the following way:

> The workers responsible for the daily living of children are not perceived to have any particular expertise. Living is a non-dynamic activity. So, the "quantity" hours are spent here. Other, specifically trained, disciplines have the "quality" hours with the children. Children must separate those specialized moments of help from their regular supervised life experience. They are required to take different pieces of their problems to specialists concentrating on that piece. (1974, p. 11)

Although the child care workers are more involved with children than any other members of the staff, traditionally, they have only minimal authority to make decisions. Hromadka, who conducted a systematic field study of the role, functions and qualifications of child care workers in 12 institutions in the mid-Atlantic region, concluded that "the only area in which all child care workers at all institutions were free to make decisions was that of determination and assignment of housekeeping chores to children." (1971, p. 182)

In its most restricted form, that role is defined as child maintenance--"to provide a safe, benign and hygienic environment for the child between psychotherapy sessions." (Whittaker, 1972a, p. 104)

A somewhat less restrictive role delegates some responsibility for carrying out the prescriptions of a professional therapist in his contacts with the child. In this latter role, the child care worker's relationship with the professional therapist has been compared to that between a contractor and an architect. (Goocher, 1971, p. 12)

In both, child care workers have a much lower status than professionals, are not perceived as colleagues who share in planning and decision making. Child care workers, quite clearly, are meant to carry out the orders of others, under supervision.

The hierarchical pattern gives rise to a number of problems that can have serious adverse effects on an institution. Bettleheim considered it impossible to maintain an effective therapeutic environment "if the staff structure is based on a system of class hierarchy of those who give orders and those who are supposed to do as they are told." (1966, p. 696)

a. Child care staff tends to become dependent on professionals for hard decisions.

When problems arise with children, it becomes easy to rationalize evading or postponing action until a professional is consulted. On the other hand, if a child care worker does make a decision and act on it, he might run the risk of being countermanded. This is an invitation to inaction.

b. Staff relationships may not be a good model for, nor consistent with, the kinds of relationships ordinarily encouraged in treatment programs.

Because traditional organizations tend to exercise controls through hierarchical supervision and (potentially) punitive means, relationships tend to be impersonal and formal. A bureaucratic organization is characterized by Davis & Tannenbaum (1969, p. 67) as having "a rigid structure, well defined functional specialization, direction and control exercised through a formal hierarchy and authority, fixed systems of rights, duties and procedures, and relative impersonality of human relationships." They point out that bureaucratic hierarchies are based on an assumption that man is inherently bad; that employees need to be controlled and forced, by punitive means, to do their jobs. Thus, the values expressed may conflict and interfere with achieving goals sought through individualized treatment.

c. When child care staff have low status, low pay and little opportunity for advancement, turnover tends to be high and the quality of job applicants low.

The recent literature contains numerous articles recommending the upgrading and professionalizing of child care staff, for all of these reasons. However, the position of child care workers in a hierarchical organization tends to make training redundant. For what should the child care worker be trained if his role is bound by demeaning restrictions?

2. Difficulties Stemming from the Isolation of Functional Groups from Each Other

Traditionally organized treatment institutions often have difficulty integrating the efforts of different staff groups and specialists so that they work toward common treatment goals.

> In recent years, the elevation of so many specialties to professional status has in some ways served to the detriment rather than to the benefit of the children in care. For example, in the course of a single week's time, the disturbed child might be expected to see his psychotherapist, group therapist, family case worker, occupational therapist, recreational therapist, music therapist, and so on. The implicit assumption, of course, is that each specialist brings his particular knowledge and skill to bear on the child's problem in such a way as to produce a single, lasting treatment effect. The difficulty is that children usually do not come to treatment with such neatly encapsulated "well defined" problems. In addition, such a model provides little flexibility in that what is actually accomplished has more to do with a particular area of competence of the specialist, than with the needs of the individual child. (Whittaker, 1972a, p. 104)

Organizational vehicles to coordinate staff effort may not exist, or even when they do, commitment to them may not be strong enough to produce unity of action. In some traditional institutions, professionals and child care staff may (on paper) be grouped into "teams." However, their role group affiliation likely will remain a more important influence on their behavior than their team affiliation, particularly if they continue to be supervised by persons from their own role groups. Supervisors tend to reward behaviors consistent with the norms of role groups, which may not be consistent with treatment objectives. Social sanctions by colleagues to whom staff are closely tied by professional or departmental bonds similarly will outweigh the importance of recognition by colleagues on a team. Thus, the "team" of the traditional institution may have only rhetorical significance. As long as the departmental structure is preserved, it is not the team described in Chapter III.

> At a cottage staff meeting, a therapist was being attacked for intervening directly with one of the "problem" children. She had taken him home for a weekend against the wishes of cottage staff, who perceived her intervention as

> rewarding the child for bad behavior. She believed that the experience would be therapeutic because the child was depressed. Although the staff called itself a "team," the meaning was empty of real significance. It was obvious that the therapist had made the decision unilaterally, without planning or discussion with the others. It appeared that her working in an office far from the living unit had contributed to a lack of coordination.

Integration of staff effort is not as important in institutions with relatively uncomplicated custodial or child care objectives as it is for institutions for which treatment is at the heart of their mission. In custodial institutions, different staff groups may be able to engage in different activities effectively, even though they do so in relative isolation from one another. Because such institutions ordinarily do not develop goals for individual children, each staff functional group can have its own goals. So, the goals of child care workers are to maintain the child in security and good health; of recreational staff, to carry out recreational programs; of school staff, to teach the children; of clinical staff, to provide their particular services. In a manner of speaking, the goals of such institutions is to provide a setting in which the various processes constituting each program can be carried out; the program is considered to be the sum of the processes.

By organizing staff into role groups, the traditional organizational structure creates a context for ideological conflict: Ideologically homogeneous role groups (that tend also to be socially and educationally similar) are likely to develop considerable solidarity against ideologically dissimilar role groups. In particular, the traditional organization institutionalizes the split between a custodial orientation (represented by the child care workers) and a treatment orientation (represented by professionals). Because child care staff carry out child care functions in the absence of professionals and because they control information about events in the living units, they in fact control treatment practices. (Scheff, 1961, pp. 93-105) Thus, in most institutions the traditional organization of staff into role groups may predispose cottage staff not to implement therapeutic decisions made by professionals.

Creating a structural split between child care workers and professionals likely will also affect the institution's ability to make desirable changes. The child care workers, who are most remote from and least identified with the professionals who set institutional goals, are likely to resist their efforts to make changes to improve program effectiveness. Because they have control over the child care process, the child care workers may block efforts to make improvements as long as they do not share the professional's goals. (Pearlin, 1962, pp. 325-334)

B. How Decentralization and the Team Organization Resolve Problems Inherent in Traditionally Organized Institutions

By minimizing the hierarchical differences that typify the traditional organization, the treatment team organization:

- Reduces dependency on professionals and encourages child care staff to use their personal skills and resources.

- Improves staff interpersonal relations and helps make them consistent with the values of treatment.

- Softens the resentment of child care workers against professionals who formerly would exercise authority without having corresponding responsibility.

- Encourages child care workers to develop their skills, enriches their job, improves the quality of applicants and reduces turnover.

> The new role for the child care workers and a new methodology for their practice were the keys to this shift in orientation from treatment of pathology on a one-to-one basis to concentrating on individual and group processes in which staff and children could work together in a context of shared real life experience from which they could see results and derive the accompanying satisfactions. Two very clear by-products emerged. The job of the child care worker became infinitely more complex and turnover decreased among the ranks of those workers who fully involved themselves in the entire process. (Barnes & Kelman, 1974, p. 15)

- Unifies those who plan with those who implement, enhancing possibilities for improving program effectiveness.

> The organizational separation of goal-setters and goal-getters cannot work effectively... as long as they are oriented to different ends. In order to overcome opposition, an institution must recognize and deal with such elements of its structure, either by having the lower groups participate more actively in the plans for change or by having the goal-setters participate more actively in the goals. (Pearlin, 1962, pp. 325-334)

By replacing the departmental organizational structure with an interdisciplinary work group, the treatment team organization:

- Replaces the focus of attention on (often) uncoordinated activities and processes with integrated action and shared responsibility for a child's progress.
- May mitigate ideological conflicts--if identification with the team and its goals becomes important in relation to role group identification.
- Reduces isolation of role groups and consequent concern with parochial professional interests.
- Helps reconcile conflict-based staff differences in commitment to the institution's need for stability and maintenance and the child's need for individualization of treatment.
- Replaces non-functional competition between role groups with interdependence between the members of different role groups of the same team.

By breaking up the solidarity of role groups and by reconstituting work groups to be heterogeneous, the team organization minimizes ideological conflict between individuals belonging to different role groups. Articles by Weber (1957, pp. 26-43) and Piliavin (1963, pp. 17-25) contain a thorough discussion of conflict between role groups. Working together toward goals that are developed in open discussion helps staff members compromise their personal ideological differences. Furthermore, because professionals work with child care staff in living units, representatives of the two role groups have considerable mutual influence on one another: Professionals can better understand the difficulties inherent in the child care job; child care workers can understand the significance and importance of individualized treatment.

The team organization should help a child care worker resolve his difficult position between institutional management's expectations that he run a tight ship and pressures from professionals that he individualize his handling of children. Because team decisions are shared, the child care worker no longer should be the man in the middle. Furthermore, because a team can speak to institutional administrators with one voice and as a group, they may be in a favorable position to negotiate such issues with institutional administration on behalf of an individual child.

Because the team provides a setting for all to bring their special talents to a focus on the needs of a specific child, as Whittaker points out, the team "wreaks havoc with the traditional notion of 'who does what' in a residential treatment center." Because professionals no longer work in the sanctity of an office, but do most of their work within the cottage unit, their successes and failures are more open to scrutiny. On the other hand, in Whittaker's opinion, "Nothing serves to strengthen the relationship between child care worker and therapist more than the sight of the professional groping to find a way to manage a child with whom the child care worker has been having difficulty for an entire morning." (1972a, p. 105)

Whittaker presents the following criteria for a "unified theory base for residential therapy:

1. That it be developed from the needs and requirements of children in care and not from the needs of any professional group.

2. That we ask, "What needs to be done in a truly therapeutic milieu?" rather than start with a preconceived notion of what persons are eligible to perform certain tasks.

3. That this theoretical framework be broad enough to incorporate current and future innovations and not be limited to a single point of view.

> It is clear by now that the models of residential treatment that will survive will be those that are self-consciously eclectic and flexible enough to adopt new strategies and techniques as they are developed. (1972a, p. 105)

VI. Difficulties Inherent in Decentralizing Decision Making

Decentralization permits greater flexibility in decision making and, therefore, increased individualization of treatment. Decentralization, however, places new stresses on organizational integrity; an important consequence of decentralization is a loosening of organization coordination and control. Although organizing into treatment teams increases the integration of staff members from different role groups at the service-providing level, movement toward decentralization loosens other organizational ties; vertically, between an institution's director and operating subsystems (living units, an on-campus school); and horizontally (among the subsystems).

This chapter presents examples of difficulties associated with such loosening ties, from the perspective of an institution's director, and at the subsystem level, in particular, among living units. Succeeding chapters discuss the new role of institutional management in remedying problems of lack of integration.

A. Resistance of Directors to Delegation

Insofar as decentralization means that institutional staff at the level of child care increasingly make decisions, the role of a director changes. In a decentralized institution, he is much less involved in making decisions about children. Abandoning decision-making prerogatives can be difficult and painful.

> When I stopped chairing meetings of the admissions committee, I felt I was no longer needed. (A director of a recently decentralized agency)

Decentralization cannot work unless an institution's director gives his staff a clear mandate to assume authority in specified areas. Staff members can feel responsibility and ownership only when they have clear deed to an identifiable purview. Might a director intervene, nevertheless, when he fears that a particularly unwise decision is about to be made? If his intervention is to provide information, or to call attention to an undesirable consequence of the decision, he probably can speak out without provoking a negative staff reaction. If he intervenes to veto a staff decision--especially if he does so without discussion or without providing a good and acceptable reason--he can expect a negative reaction.

One director saw the advantages, in principle, of delegating the right to make operational decisions to his staff. He agreed with members of his staff that they should assume responsibility for many decisions. However, he seemed to them inconsistent in his willingness to live with their decisions. At some times he accepted them without comment. At others--and unpredictably--he would intervene to make decisions for them or to countermand decisions they had made. The staff felt that he was being arbitrary and capricious. Some felt resentful and demoralized. As time went on, they tended to withdraw from decision-making responsibilities to avoid having conflict with him and to avoid the humiliation they felt when they were countermanded.

Before delegating decision-making authority over any area, a director should be certain that he means to commit himself to that delegation.

Delegation is most likely to succeed when a director has confidence in his staff and can tolerate differences of opinion and (even) errors of judgment. When staff members make errors--and it is inevitable that they will (as will directors)--they have an opportunity to learn from their experience. One of the most important functions of directors who want to move toward decentralization is helping build staff competence to exercise their new authority effectively.

Directors may be reluctant to delegate authority because they feel that their staffs are not prepared to assume such responsibilities. In agencies with staffs that have had long tenure--especially in agencies that traditionally have been administered according to a medical model--staffs have not been accustomed to assuming decision-making responsibility or taking the initiative in making decisions. In other institutions, staffs may be new and young, lacking in the experience and training that is necessary for them to act autonomously. Some staff members may tend to become punitive with children if they are given more authority than they are comfortable with and have less access to a supervisor on whom they can depend.

Under such circumstances, an institution might need to move somewhat cautiously toward decentralization. Beginning with an organization that is relatively centralized (and, necessarily, offering services that are somewhat less individualized), institutional management might plan a series of steps toward decentralization, including assessment of training needs, training experiences coordinated with a new delegation of responsibility and gradually expanding areas of decision-making authority and reassessment before taking a next step. By moving forward in a planned and orderly manner, a director may himself feel confident that he is not delegating more responsibility to his staff than they can handle.

Even though a director has delegated authority over certain areas, he must--in order to fulfill his own responsibilities to his board of trustees and other superordinate bodies--stay well informed about events within the institution. He may no longer be as free to make decisions in those areas as he formerly was because that would be meddling. But he retains responsibility for knowing what is going on. He needs to spend time with the staff and with children. Well-defined accountability procedures can provide him with information about agency performance on a formal basis.

B. Unit Autonomy

Decentralization increases the autonomy of an institution's living units from the institution's management and from each other.

On one hand, increased autonomy is desirable. Autonomy permits units to tailor their programs in accordance with the needs of the children in the unit. Treatment goals can more readily be set for and with individual children and treatment planning can be more responsive to the characteristics of the individual child and the day-to-day experiences of unit staff.

Furthermore, autonomy permits experimentation that can lead to program improvement. Because units are freed from most central constraints that produce uniformity, they naturally will tend to vary among themselves in how they care for and treat children. Scrutiny of such variations and their consequences--even intentional variation to experiment with and compare the effectiveness of different methods--is one important way that an institution can learn to improve.

> For example, two units could try goal planning in two different ways to see which way was more effective. One unit might try setting goals collaboratively--including in the decision all members of the treatment team and the child, his parents, representatives of outside interested agencies (a referring or placement agency), etc. Their experience and results could be compared to those of another unit in which goal planning is done by the cottage staff or, perhaps, only by the treatment supervisor or case worker.

On the other hand, the advantages have concomitant disadvantages.

> In one agency, residential facilities traditionally were organized along dormitory lines. Management was carried out by a centralized administration. The agency changed that system, so that the dormitories were reorganized into smaller units, each of which had its own staff composed of child care workers, social workers, and a supervising cottage coordinator who had both administrative and child care responsibilities. An organizational consultant (from the HIRI project) attempted to work with the staff of one unit, to improve their organization and processes so that they could become more effective in treating children. He wanted to develop the unit as a model for the other units in the agency so that they, too, could be helped to improve.
>
> One of his first interventions was to ask the unit staff to examine their own processes to identify events, activities and responsibilities they felt were effective and worthwhile. The staff members resisted the exercise. Discussion revealed that they thought of themselves as an island of effectiveness in an institution that was unsupportive of their efforts with the children (more concerned with administration and policy than with the children). The child care workers especially had purposely isolated themselves from the rest of the institution, dealing with it through an emissary, their social worker, who maintained a relationship with the administration, the parents and outside agencies. They did not want to engage in any activity with the consultant that might require becoming reinvolved with the institution.
>
> In another agency, living units became autonomous, partly in the course of movement toward decentralization and partly because of weak and confused overall management. In this agency, the professional staff worked in an administration building and engaged in activities in the units only on occasion (for case conferences, staff in-service training, etc.). The living units were supervised by middle managers, most of whom were young, masters-level college graduates in the social sciences. In the area of professional activities (especially) the role of the institution's professionals and that of the middle managers had not been clearly differentiated. This ambiguousness combined with very poor personal relations among the unit supervisors, and between the professionals and the director, led the unit supervisors gradually to expand their area of authority.

Eventually, each unit came to control all of its own intake, treatment and termination. Having laid claim to the major business of the institution, the unit supervisors were willing to let the professionals have everything that was left over. They justified this stance by stating that the professionals had no special knowledge about running the units that made them any more expert than the cottage staff. Furthermore, the unit supervisors refused to be supervised by anyone whose legitimacy they questioned--that is to say, by any of the professionals. The unit supervisors also maintained independence from one another: They chose not to meet or work as a group. Thus, each unit came to be run as an independent operation. The units frequently were in conflict with one another and with the central administration.

Decentralization of the children's unit of a large state hospital resulted in the development of eight "mini-hospitals" and a school. Each "mini-hospital" operated as an almost completely autonomous unit. Their programs differed widely in quality, sophistication, staff organization, and clarity of goals. Because there was little interaction between units, that which was good or poor in any one unit was rarely known in the others, and good practicies did not spread throughout the organization. Because the goals of the different units were not clearly stated, there was no way to know to what extent they were being met. Relations between the units were characterized by unproductive competition for resources and by conflict.

The examples illustrate how unit autonomy can have grave, even disabling, consequences for an institution. Autonomy can lead to marked organizational disintegration. The staffs of different units may tend not to form or maintain a sense of overall institutional mission or even (sometimes) the goals of their own unit because an autonomous unit within the context of a larger institution is not likely to create goals for itself except as they are derived from or are in some way related to the overall institutional mission. And if autonomy weakens the ties between a unit and its institution, its sense of purpose tends to become indistinct.

Unit autonomy may have a number of other consequences:

1. Program coordination becomes difficult.

   Each unit may develop its own program, without regard to the programs of the other units.

2. Competition for resources may lead to their inefficient use.

3. Different units may develop different policies.

   For example, in one institution each of several autonomous units had different arrangements with the on-campus school about how to deal with disruptive children. Discrepancies and inconsistencies between these management policies resulted in confusion both to the students and the staff.

4. The staff might lose their identification with and feeling of responsibility for the institution.

   They might, for example, develop parental feelings toward "their" children and not pay attention to or take responsibility for children from other units, even in crisis situations. (The converse might also take place: Children might tend to resent staff members from other units when they try to assert influence or authority.)

For all of the above reasons, an institution should move cautiously toward decentralization. The staff must be capable of operating under those circumstances and the institution needs to create an organizational context that maintains integration against the potentially divisive forces that are inherent in organizational autonomy. The next chapters describe a new role for institutional management in creating an integrative organizational context.

VII. The New Role of Management: The General Objectives of Managers

In the preceding chapters, we discussed those organizational matters most directly related to the delivery of individualized services to children. In particular, we discussed the decentralization of decision making, and the organization of staff into teams as ways to meet organizational requirements imposed by the individualization of services. The management of teams was part of that discussion.

In this chapter, we begin a discussion of institutional management or managers rather than the director, for a number of reasons. In an institution in which decision making is decentralized, there is no single director in the traditional sense; management at the institutional level might no longer be vested in one person. In some institutions, managerial responsibility may be shared by an associate director or within a management group or committee. In more traditional organizations, an assistant director might assist the director in carrying out the director's decisions; in a decentralized organization, associate directors may be delegated responsibility and authority within a certain purview. Staff members throughout the organization share in the decision making. In general, a decentralized institution's managers no longer direct the activities of staff. Top management's new job is to create and maintain an organizational structure in which decentralized decision making can take place.

Middle management includes a somewhat more diversified range of tasks than in traditional organizations, where middle managers generally are supervisors who direct (and monitor) the activities of line staff members. In a decentralized organization, middle managers act as leaders, resource persons and coordinators. They are much more likely to take responsibility for seeing that something is done by supporting those who perform a task than they are to direct staff in doing it. As resource persons, they are concerned with developing staff skills, that is, staff ability to take responsibility for carrying out tasks without direction. In a children's residential center, middle managers take responsibility for such activities as in-service training, case conferences, intake, placement, team coordination, and for the management of subsystems (living units, an on-campus school).

In traditional institutions, becoming a supervisor confers a more or less permanent status that makes the person eligible to assume managerial responsibilities. In decentralized institutions--especially those organized as open systems (see below)--staff members may act as managers temporarily, either because their particular skills are not needed over a long term or because the function for which they assume responsibility (for example, leading an ad hoc committee) may be transitory. Authority and leadership tends to be vested or assumed on the basis of expertise rather than because of status. Thus, any staff member is eligible to assume management responsibility because he has some particular skill that qualifies him to take leadership in a particular activity.

A. Major Objectives

The objectives of managers of a children's residential center are to organize an institution that is responsive to a certain range of community needs and to integrate that organization with its environment as well as internally, so that its staff carry out activities that are for the benefit of children and that also fulfill needs in the environment. The managers, then, clarify and enunciate the particular mission of their institution, design a treatment process to achieve that mission, recruit and organize staff to carry out the tasks of which that process is composed, and maintain an integration both of staff within the organization and between the organization and its environment.

In providing individualized treatment, a CRC likely uses some combination of a number of technologies (behavior modification, transactional analysis, education, group therapy, psychoanalytical therapy, etc.) that may be effective. Each technology requires appropriate staff skills and some one or some group with those skills accepting responsibility for the activities.

It is important to recognize that any one way of organizing staff is not sacrosanct. Because the responsibilities for the activities required by any given technology may be divided and grouped in different ways, work can be organized in different ways and, therefore, different organizational structures may be able to carry out the same technology.

Managers and institutional staff members often do not recognize the flexibility they can have to redesign their organization, to reallocate responsibilities among the staff, and even to experiment to see which organization of work may be best, given the particular constraints characterizing their institution--primarily, the available resources, the staff and their skills and interests.

Many managers plan organizations so that work is distributed in stereotyped ways in accordance with the traditions and prerogatives of professional role groups. However, those traditions may not be consistent with the best interests of the children being served by a treatment program.

> Managers need to define the role structure of the child care institution--who does what--in terms of what needs to be done, instead of having a preconceived notion about what the functions of the various professional and non-professional groups should be. In this regard, a classification for assigning duty functions according to children's needs and staff skills, rather than professional needs, is sorely needed. Too often, group care is related more to professional preference than to the actual needs of the children. (Whittaker, 1972b, p. 55)

B. The CRC as an Open System

Because children's residential centers need be responsive to environmental expectations and need to carry out the operations required by a technology to achieve their mission, they might be helped by general guidelines for their organization. We present some formulations about guidelines as they grew out of the periodic team discussions that took place during the HIRI consultation project. We found ourselves discussing the organization of children's residential centers in the language of contemporary systems theory because the constructs of that theory seemed to fit the phenomena we were considering. In particular, we found that the organizational model proposed by open systems theory, as first formulated by A. K. Rice (1963), was useful in discussing issues of organization as they were manifested in the children's residential centers in which we were working.

The open systems model compares an organization to a living thing. Materials are imported from the environment, across the organization's boundaries; the materials are transformed in a conversion process, within the organization; the transformed materials are exported back into the environment; feedback from the exports or their impact influences the nature and flow of imports. In In most organizations, top management regulates the transactions across its boundaries; responsibility for the conversion process is delegated to middle management.

Translated into the terms of a treatment-oriented children's residential center, children flow into the residential center in an intake process; they undergo beneficial changes in the course of the treatment process within the institution; at the end of treatment they are placed back into the environment; the rate of placement and the effectiveness of treatment have a consequent influence on intake (feedback). In many institutions, the director assumes responsibility for the institution's relationship with its environment; an associate director takes responsibility for internal management.

Managers of children's residential centers might consider a number of general guidelines, implied by open system theory, when they examine the organizational characteristics of their institution.

1. The organization needs to be designed as a system, to promote adequate interrelatedness of individuals, work groups and management.

   Roles should be described in terms of responsibilities as those responsibilities interlock with those of other jobs. Work groups, meetings and accountability procedures should be designed to facilitate interrelatedness.

2. The organization should be designed as an open system.

   Because their basic process involves absorbing children from the community, treating them in some internal program and releasing them back into the community, CRCs have a high degree of interrelatedness with and dependence on their environments. Their environments are changeable and they may need to position and reposition themselves in relation to those changing conditions. The organization should be designed as an open system that maintains close contact with those parts of its environment on which it is dependent, and in terms of which it must adapt if it is to be viable.

   An open system organization anticipates and has a way to plan to respond to environmental changes such as changes in referral sources, categories of children being referred, birth rates, performance expectations, financing and standards, the availability of placement opportunities in the community, etc. In particular, environmental changes often require that a CRC learn to do new things or learn to do some things better if it is to survive.

   > For a dozen years, the probation departments of several counties had used a children's residential center (not one of our institutions) as a treatment facility for emotionally disturbed adolescent girls. During their placement, these children attended community schools and appeared well accepted by local residents. Changes in public policy required that the probation departments begin to place such children in community settings (foster and small group homes). New referrals would be more severely disturbed and delinquent children.

> The director fruitlessly attempted to persuade the referral sources to continue to refer the same kinds of children. She feared she might have to close the institution because their program and organization were not designed to treat disturbed children, and she anticipated that the surrounding community would not tolerate severely delinquent children. It was obvious that the institution had not prepared itself to respond meaningfully to a change in kinds of referral. That is, it was not responsive to changes in environmental expectations as an open system would be.

3. An open system that organizationally provides the capability for learning on a continuing basis becomes a learning system.

   Children's residential centers that are responsive to environmental changes and that strive to improve their effectiveness can further design their organizations as learning systems. A learning system contains organizational structures that identify staff needs to learn new skills and institutional needs to acquire resources with new skills, and a way of assessing organizational effectiveness so that areas in which improvements are needed can be identified.

The following questions may be used to identify significant characteristics of a children's residential center, in order to analyze it as an open system.

- What is (are) its primary task(s)? What does it have to do in order to survive in a universe of need?

- What is its environment? What are the expectations, pressures and resources available from the environment?

- What is the nature of its boundaries, both internal and external? How is the institution separated from its environment, and how do transactions occur across those boundaries? How are its internal components separated from one another, and what is their relationship?

- What does it export? What moves from the institution into the environment?

- What are the constraints within which it must operate? What are its resources? What are the rules and regulations governing its operation? What are the resources it has available? (O'Connor, 1974)

The following chapters describe, in greater detail, the role of management in a decentralized institution designed as an open system.

VIII. The New Role of Management: Managing Boundaries and Institutional Definitions

Children's residential centers are confronting increasingly demanding and complex environments. Although they always have had an interdependent relationship with their environments, they once could be somewhat removed from them. In recent years, however, the traditional acquiescence of the public to the authority of institutions and professionals has diminished. The public no longer accepts unquestioningly the right of institutions to define the populations they choose to treat, to determine length of stay and to treat or not to treat at their discretion. External constraints and expectations increasingly affect institutional goals and programs and increase institutions' needs to explain themselves and justify their existence. Maintaining an institution's relationship with its environment--boundary tending--occupies a much greater part of management's time than ever before. As the need to manage transactions across boundaries increases, the directors of institutions no longer are able to manage both their boundaries and their internal operations. Under these circumstances directors may need an associate (director) with whom they divide those management responsibilities.

A. Managing the Institution's Relations with Its Environment

An institution's director is the logical choice for managing transactions across the boundary between the institution and its environment because, as director, he is accountable to the community, the board of trustees, and superordinate agencies. The institution vests authority in him to speak for it.

> ...Any leader of an enterprise or part of an enterprise has the task of controlling the boundary conditions of the enterprise or the part of it that he leads. (Rice, 1963, p. 253)

As the boundary manager, a director typically becomes involved in the following kinds of activities:

1. Interpreting the institution to its environment.

The director is the voice of the institution, explaining its mission and program to referral sources, funding agencies, other related systems and the public.

When an institution is geographically located within a community, the director plays an important role in maintaining good relationships with neighbors and community groups. The establishment of group homes as an extension of the residential facility may require the manager to maintain a broad base of community support. A good relationship can help promote the acceptance and tolerance of deviant children who occasionally may disturb the community's tranquility. The director of one institution recruited community groups to participate in a recreational program and to accept children into community homes for evening or weekend visits.

2. Interpreting the environment to the institution.

The director informs an institution's staff about changing conditions and expectations in the institution's environment. That flow of information is especially important in a decentralized organization because it enables work groups to adjust and adapt their activities to such changes. Institutional viability may depend upon it. For example, institutions for delinquents face frequent changes in community expectations. At some times, dramatic exposés of undesirable conditions in agencies dealing with delinquents can arouse community demands to improve programs promoting rehabilitation and early release. Within days, because of a violent juvenile crime, the same community may demand tighter controls and longer periods of confinement. An informed staff, to some extent, can help maintain institutional viability by adjusting their priorities in accordance with such environmental changes in expectation. By the same token, the boundary manager can be a buffer between the environment and the staff: By interpreting the institution's constraints to the environment, he may temper the environment's demands on it; by providing realistic information to the staff, he can modulate the impact of changing and sometimes unreasonable environmental demands.

3. Negotiating for support and resources.

Even in institutions supported by tax funds which provide a yearly budget, a manager by no means can be certain that his budget will be smoothly and automatically forthcoming from year to year. Managers of private institutions who must scramble for their budgets may envy the apparently steady flow of money available in a tax-supported institution. However, competition for funds in such institutions often makes it necessary for their boundary managers to devote a considerable proportion of their time to insuring that superordinate agencies maintain necessary budget levels.

4. Maintaining relations with the policy-making board.

A board can help a director deal effectively with an institution's environment. The director, however, must provide his board with data which enables its members to make informed judgments. A working board (as contrasted with a ceremonial board) can be an important source of contacts and support in matters affecting the institution from without and a consultation resource for some internal matters. In one agency, influential members of its board of trustees gave testimony supporting legislation favorable to children's residential centers to a committee of the state legislature. In another, an ad hoc committee of the board joined with staff representatives to insure that affirmative action requirements were appropriate and clear as the institution prepared to fill two management positions.

5. Developing new community programs.

Directors of some institutions work in their communities to develop day care centers and after-care group homes, helping their institution reduce its cost of care and thus, in the long run making it more viable. Creating a system of care enables an agency to use less expensive care in the community to supplement and partly replace more expensive institutional care when that is not necessary for effective long-term treatment.

6. Approving and supporting staff involvement in consulting with community groups.

As an institution develops a reputation in the community for having expertise in certain kinds of program and activity development, its director is often requested to provide consultation on the subject. The director of one agency was approached by the city recreation department which asked for his assistance in planning their summer day camp program. The director then met with the unit supervisor who had been responsible for the institution's day camp program and suggested that he and his staff provide the consultation the city needed.

7. Planning for the long-term.

> The director who stands on the boundary between the institution and its environment can sense and anticipate the community's needs for the institution over the long run.

> One institution director who recently assumed the responsibilities of boundary management (and delegated a large part of the responsibility for internal management to an associate director) describes his new role in some ways as that of navigator rather than pilot. As "navigator," he feels that it is up to him to know the direction in which the institution is going... His associate director is the "pilot" who flies (operates) the institution from within. Relinquishing responsibility and authority for operations (as he put it) "gives me a little more time to really check the checkpoints as the navigator. To be able to look down the line and to think about reducing the number of beds in residential care, and put more emphasis on the combination of foster homes and a treatment center." He thinks about new kinds of mixes of services that his agency can provide. He is aware of the agency's need to be able to change, to respond to changing needs in the community. "The reality is that as soon as we begin to get comfortable with something, we'd better be thinking about what the new needs are."

Although the director is responsible for managing transactions across his institution's boundaries, he may want to delegate responsibility for some activities to others--for example, to members of his board of trustees and staff whose resulting increased familiarity with environmental challenges and opportunities can help them become more effective on behalf of the institution.

An associate director typically takes responsibility for some transactions across the institution's boundaries. Because he is responsible for managing the treatment program, he also is responsible for maintaining occupancy at a reasonably high level. In turn, he may delegate that responsibility to middle-managers who are more directly responsible for intake and placement. If he does so, however, he should expect the middle-managers to be accountable for their decisions.

> In one institution, unit supervisors each were responsible for their own unit's intake and placement activities. Because they had not agreed upon an accountability procedure when the director delegated that authority, the unit supervisors made decisions without regard to the impact they would have on the

> total population of the institution. They felt little responsibility for total occupancy. The institution ran at a deficit because occupancy was maintained below the break-even point.

B. Developing a Statement of Institutional Mission

An agency's management ordinarily is the authoritative source of its definitions--statements of mission that express why it exists, what it is prepared to accomplish.

Definitions of institutional purpose can be very difficult to formulate because they need to take into account a complex set of determinants: community needs and priorities; an institution's constituents; (on the staff, in its environment and its clients) and less visible constraints. Statements of mission are approximations, "best fits" that accommodate, if temporarily, as many considerations and constraints as possible.

Why have a statement of mission? In a decentralized institution, a statement of mission can play an important coordinating role in maintaining its systemic integrity. When an institution's staff members are not committed to achieving the same mission, they may begin to work at cross-purposes.

> Four child care workers in a living unit wanted the unit supervisor and social worker to discharge a troublesome 14-year-old-boy from the institution. As they expressed their wish at a unit meeting: "If he isn't making it in school and isn't making it in the cottage, he doesn't belong here." They felt that the child was sabotaging their efforts to do their job (as they perceived it): to run the unit as a tight ship and sail it on smooth waters.
>
> The supervisor and social worker were resisting the pressure. They were not holding the child care workers responsible for running the unit smoothly. They interpreted the CCW's job as working with the child to help him deal better with his emotional and interpersonal difficulties--not simply to get him to fit into the context of the unit without disrupting it.
>
> The CCWs appeared not to understand the position taken by their supervisor and the social worker, and were obviously dissatisfied by the discussion, which did not come to a clear-cut conclusion. As they saw it (somewhat bitterly) they were being sabotaged in their efforts to do a good job, and for venal reasons. They believed that permitting the child to remain in

the unit was due to a policy of keeping the institution's occupancy rate high for financial reasons. The discussions did not come to clearly understood conclusions because the participants apparently were proceeding from different premises about the institution's purpose, but did not recognize and deal with these differences.

The example illustrates one of the consequences that can result from a lack of basic agreement about an institution's mission. In this institution the lack of agreement was related to absence of an explicit statement or understanding of the reason for the institution's existence.

Having an explicit statement of mission means that an institution's staff, board of trustees, the community and its clients can answer the following question: What is this children's residential center here to do? Such a statement is desirable for a number of reasons:

1. The statement helps the community understand the institution's role--what kinds of children it accepts and what it tries to achieve with them.

   The community, and the organizations that represent it (in particular, funding and referring agencies) can know how to support and use the institution as a resource. Furthermore, if the community has changing needs for services, the statement of mission provides a way for discussing changes that the institution might consider making. Thus, periodic reviews of the statement in the light of information from its environment provides a way that an institution can maintain its viability as a useful resource.

2. A statement of mission serves as a statement of institutional values.

   Knowing what their organization stands for provides staff members with a basis for identifying with their organization and its values. When values are internalized they can serve as a source of motivation.

3. A statement of mission serves as a guide to organizational design.

   An institution's mission provides a basis for identifying its primary tasks. In turn, the operations that make up those tasks provide a basis for designing its staff organization.

4. A statement to which all staff members can subscribe provides a foundation for staff unity.

   A sense of unity in relation to the broadest and most important issues can help modulate and contain conflict over particulars which then will tend to be perceived as somewhat more superficial and less threatening.

5. A statement provides an institution with a sense of direction and enables a large number of staff people to mobilize their efforts around a common aim. (Olmstead, 1971, p. 120)

   Everyone can stay on the same track and work together efficiently. An explicit statement may become particularly important in a children's residential center where units may function relatively autonomously--both from administration and from each other--and individual staff members can function relatively independently within units.

6. An explicit statement gives everyone on the staff equal access to basic institutional definitions and enables everyone to use his own judgment in making decisions.

   The invitation to use that judgment develops an egalitarian staff. Egalitarian relationships promote the kinds of discussion and decision making that best serve the purposes of treatment.

   Staff access to important institutional definitions may have special impact when the institutions are attempting to change from a hierarchical, authoritarian system to a decentralized organization.

   > An authoritarian system is necessarily weak in operational ideology because it must resolve issues by appeal to the superior officer rather than by appeal to principle. Authoritarian discipline is subverted by the publication of principles to which an appeal from persons can be made. Given a constitution or a law of the 12 tables, the weakest man in the community is armed with a weapon against the strongest. (McCleery, 1964, p. 388)

7. A statement of mission provides criteria for evaluating institutional effectiveness and performance.

   Externally, the criteria provide a basis for evaluation by boards of directors, referring agencies, licensing bodies and funding agencies.

Internally, the criteria provide a basis for evaluating institutional activities, programs, practices and procedures.

Two questions provide the evaluative framework:

- How does this procedure or program help attain the goals implied by the mission?
- Is this program or procedure consistent with the values implied by the mission?

At a more concrete level, those questions become:

- Does this meeting help us plan or implement activities that contribute to institutional goals?
- Does taking children to the movies contribute more or less to treatment goals than taking them bowling?
- Does giving children an allowance for behaving in school contribute to program goals?

C. Management's Responsibilities for Statements of Mission

An institution's director likely should assume responsibility for developing and enunciating institutional definitions. As the person who is astride the boundary between the institution and the community, and as the one in most direct contact with its board of trustees, superordinate agencies, components of related systems, interest groups representing clients and funding agencies, he is in a better position than anyone else to know the needs of the community and the possible roles that his institution can have in relation to those needs.

The director also can identify that role to which his institution is best suited by virtue of its access to external and internal resources. If, for example, the institution has poor access to professional consultants, it might not be able to run a program for seriously disturbed children or to operate a facility for the very severely handicapped, even though such needs existed in the community and the institution was greatly interested in addressing them. Similarly, the existing internal resources of his institution--the physical and staff assets and liabilities--and the potential for developing or acquiring additional resources constrain the institution's choice of roles.

The director can give leadership to developing a consensus about an appropriate statement of institutional mission among interested persons and groups both inside and outside the institution. If an institution's statement of mission is developed with the participation of interested individuals and groups, it is likely that they will then support the priorities and programs that are (then) created or adapted to implement that statement of mission. The director also takes leadership in reviewing definitions and changing them as it becomes necessary. Again, he likely will need support both from outside the situation--especially from his board of trustees--and from his staff. He can use his authority and influence to direct attention to the need to review or change the statement of mission and can organize appropriate vehicles to consider making changes.

D. Some Desirable Characteristics of a Statement of Mission.

A statement of mission should have characteristics that enable it to be as useful as possible. Following are some characteristics that should be considered when an institution is developing such a statement.

1. A statement of mission is a statement of purpose.

It should accommodate community needs, staff interests and the constraints (physical, staff, regulatory) within which the institution must operate.

Because its usefulness derives from its potential for generating guidelines, evaluative criteria and goals, and orienting staff and others to the institution's role, it should be stated in rather specific terms and in terms of desired and attainable results.

The statement should imply attainable goals that can be measured. It may not be taken seriously if goals are too remote or too grandiose for staff members to be able to plan effective programs for reaching those goals.

Although it is important that the statement is capable of being operationalized, it should not itself indicate the means or the operations that enable the institution to fulfill its intentions. The particular processes the institution will employ grow out of the needs of the children, its constraints (resources) and the available technology. As these change, institutional practices may change even though the institution's mission may remain the same.

2. The statement should be broad enough to include all of the tasks that must be performed in the institution for it to survive.

For example, in one state delinquent boys are sent to forestry camps which are places of detention and fairly close supervision and at which educational, social and recreational services are provided. Counselors and social workers do group work with the boys. The boys also are expected to work at fire prevention and fire-fighting tasks under the supervision of forestry personnel. Each of the activities and services described requires its own staffing and has its own process. The camps' statement of mission should be broad enough to include all of the activities.

The statement should be neither too broad nor too narrow. It should include only those aspects of a general mission that can be achieved given the institution's constraints. For example, "reducing delinquency" would be too broad a mission for an institution, since the conditions that give rise to delinquency and the context in which delinquency occurs go far beyond the institution's purview. On the other hand, if a statement of mission were to include the specification that it intends "to provide residential treatment," the statement might be too narrow and might unnecessarily inhibit the institution's activities. For example, the institution might then not perceive that it is free to create non-residential components that might be useful in providing services to larger numbers of children and in reducing costs.

3. A statement of mission should be one that a consensus of staff members can subscribe to.

As has already been discussed, the statement should avoid arousing conflict due to philosophical differences. Similarly, unnecessary difficulties probably would be encountered if the statement stipulated use of a technology about which there was conflict, such as "the reinforcement of socially adaptable behaviors."

IX. The New Role of Management: Maintaining a Flexible and Effective Organization

One of the priority responsibilities of an institution's management is tending to its organizational design. For a children's residential treatment center, the organizational design should account for all of the responsibilities and related tasks necessary for the institution to carry out its child care and treatment program.

The manager who has assumed responsibility for the internal management of a children's residential center assumes responsibility for its organizational design: for ensuring that its staff is deployed to carry out the tasks required by its mission; that the activities of the staff are integrated and focused on achieving the objectives implied by the mission; and that processes and procedures are consistent with the values implied by the institution's mission. Because decentralization increases autonomy, the manager will need to pay attention to managing to insure organizational integration. He cannot assume that organizational integration is maintained simply because appropriate groups have been formed and relationships between groups established, on paper.

> An institution recently had organized its staff into interdisciplinary teams charged with planning and implementing individualized treatment for the children. Although the staff, on paper, was organized into teams, the teams did not function effectively. Team leaders ran meetings without a clear statement of purpose; discussions tended to be unfocused; issues being discussed tended not to be resolved (either by a decision, a decision not to make a decision, or a plan for making a decision); the staff group comprising the team sometimes was not appropriate (some members were superfluous and others who should have been there absent); issues were raised that could not be resolved by those present because of lack of information or lack of authority; teams appeared not to know how to progress from discussion to action; and decisions typically occurred by default--they were not arrived at in the course of discussion but ultimately were made by one person in a relatively arbitrary manner. Frequently, discussions about problems of child management degenerated into gripe sessions; teams did not arrive at plans or make decisions to deal with issues.

The example illustrates some of the areas of concern on which a manager might profitably focus his attention. In the following sections, we list a number of such issues giving, whenever possible, illustrative examples. Some of those examples refer to interventions made by HIRI consultants in the project's study institutions. A manager might appropriately make some of these same kinds of interventions, acting almost as his institution's internal consultant concerned with creating and sustaining an organization that will support the staff and permit them to work effectively.

A. Making Changes in Organizational Design

Children's residential centers exist in a changeable environment. A wide variety of kinds of changes--of funding, referrals, expectations of referring and placing agencies, treatment technology--may have impact on the institution and may require that the institution accommodate the changes. Also, internal changes--changes in staff composition and the expertise they make available, changes in treatment technology--similarly may require shifts in the allocation of responsibilities and roles if the institution is to make the most effective use of its resources. Therefore, it is highly desirable that an institution's management periodically scrutinizes its organizational design to see if changes are necessary.

Management and staff of an institution are free to design its organization in any way they please. There are real constraints, of course--such as staff numbers, the distribution of expertise among the staff, mandates from licensing and regulatory agencies, requirements of guilds and unions. Some of these real constraints may be modifiable or negotiable; others may not. However, when institutions do not use their freedom to organize work in the manner that best suits their particular circumstances, it usually is not so much because of the real constraints as because of reluctance to deal with issues of tradition, professional prerogatives, staff uneasiness about change, and other primarily "political" considerations.

While reviewing organizational design to determine whether changes might be desirable, a manager should encourage discussion of the prevalent attitudes toward existing roles and responsibilities in order to determine possible resistances to making changes. Through discussion, the manager and staff can identify problems constraining change that may be addressed through careful planning.

When the manager and the staff analyze and review the existing design, it is extremely important that they direct their attention to the ways the work actually is being done rather than merely review the official descriptions of work roles as they might appear on the organization's personnel chart. Organizational charts usually represent line and staff relationships and official work descriptions in a superficial manner and any analysis based on those kinds of official statements will also be superficial.

1. Some reasons for redesigning the organizational structure of an institution.

   The signs of dysfunction due to structural faults are manifold, but here are a few of the typical ones.

   a. The distribution of roles, responsibilities and authority may interfere with a staff member's ability to make decisions so he can do his work.

      In a decentralized institution, roles are best defined in terms of responsibilities so that staff members can identify the area in which they need to act. Describing the role in terms of responsibility indicates that a staff member should use his judgment and is free to innovate to do his job. Defining roles in terms of tasks or activities constrains staff members from seeking better ways of doing their jobs.

      Staff members need their organization's permission to make decisions in the area of their responsibility--that is, unless a staff member has authority to act in order to fulfill his responsibilities, it is impossible for him to do his job. If he does not have the authority, or if the terms of delegation are ambiguous, he will need to go to others, regularly, in order to check out his decisions and ask permission. Not only is it inefficient, but it is also demoralizing to many staff members when they cannot use their personal resources and judgment in their work.

   b. The design is ambiguous or inexplicit.

      To be effective in guiding and coordinating the behavior of staff members, the organizational design needs to be clearly understood by everyone. To be clear, the design must cover the necessary bases, describing the responsibilities of which the roles of different staff members are made up and the interlocking relationships between roles with regard to responsibility and authority. Otherwise staff members might perceive the need for improvement, but might not be certain about who has the responsibility and right to make decisions to change. Some responsibilities might "fall through the cracks" and not be claimed by anyone.

c. Conflict between individuals or work groups interferes with work.

Conflict can have its roots in role conflict (contradictory expectations placed on an individual or group) or role ambiguity (a lack of sufficient information about role). (Kahn, Wolfe et al, 1964, pp. 387-391) A certain amount of conflict between individuals and groups having different priorities quite naturally tends to produce some conflict in any institution. Ordinarily, managers provide ways of dealing with such conflicts: by administrative decision; through negotiation between groups; by arbitration. At times, however, an institution may not be able to manage conflict, and individuals and groups become so absorbed by it that they can no longer function together. At such times, the institution may make structural changes either to strengthen its ability to deal with conflict (for example, by creating a new structure with special authority to arbitrate or negotiate) or by redefining roles and responsibilities.

> The social workers at one institution traditionally supervised units and child care staff. The institution's director relieved the social workers of their supervisorial responsibilities because it seemed to him that they did not maintain an appropriate balance between the needs of children and the needs of the agency. In his opinion, the social workers tended to be too permissive and permitted children to damage the physical plant. The director created the position of cottage coordinator to be filled by an experienced child care worker whom he felt could more likely maintain an appropriate balance.
>
> As a result, and especially because the institution did not place a very high priority on professional services, the social workers became figureheads who had little function but to satisfy official state licensing requirements that institutions employ social workers. Because they served no real function, they carried little weight and got little respect. They became embittered and alienated both from the director and the child care staff. It became clear that either a structural change redefining their jobs needed to be made or they would have to be fired.

d. When staff members complain that their jobs are unrealistic or unrewarding.

A good structural design not only defines roles and responsibilities to ensure that an institution's primary task can be carried out, but also defines those roles so that staff skills and potentials are used as completely as possible. The institution will benefit because it is putting its own internal resources to best use. In addition, staff morale is likely to be high because each person can feel that he is making an important contribution to the total effort. Reallocating responsibilities can enrich jobs so that staff members will feel more fulfilled.

> The process of negotiation (which was a part of an organization redesign procedure) provided one staff member with a means of enriching his job and fulfilling his interest. As cottage coordinator, his responsibility was primarily the care of the children and supervision of the cottage staff. In his negotiations with the social workers, he asked to be included in family conferences and contacts with the parents. The social worker welcomed his interest and made it clear that she would inform him of her work with the families and involve him in any contacts that she made.

2. What kind of change in design is needed: structural adjustment or structural redesign?

An institution's manager can review organizational structure during a systematic series of conversations with individuals and work groups. Those conversations might explore the division of responsibilities, whether all responsibilities are accounted for, how tasks are divided, mutual expectations of staff members and whether they are met--in brief, the roles of individuals and groups and how they are intertwined with those of others. It is important that these discussions cover the relationships between roles as well as the content of roles. In fact, a useful way of proceeding might be to review these matters with groups of individuals who are linked to one another in the performance of their work, (what Kahn would call members of a "role set," 1964, p. 389) making certain that the relationships within and between all groups are reviewed. In doing so, management should recognize that individuals can belong to more than one group and those groups overlap in different ways.

An institution may be able to make adjustments in its organizational structure when, in the course of discussion--either between a manager and work groups or in the process of negotiations between work groups--agreement can be reached about changes. Staffs can become skilled in identifying needs for change and in negotiating changes and may frequently be able to work out such changes to everyone's satisfaction.

One of the difficult aspects of making changes in organizational structure stems from the systemic nature of organizations: Changes made in the responsibilities, duties or authorities of one person or group require that commensurate changes be made in the roles of other persons or groups--sometimes in areas rather remote from the locus of the initial change. It is for this reason that the exploration and negotiation of change should be conducted in groups made up of persons who have interlocking functions.

Two of the HIRI project consultants* created an exercise by means of which the management and staff of an institution could make structural changes in a manner that developed staff support and commitment to the changes: The exercise provided an orderly procedure for task-oriented meetings that involved or represented all staff groups, that proceeded to reallocate responsibilities by a process of negotiation, and that developed staff skills in negotiating such changes so that they subsequently might make adjustments among themselves as often as necessary. (For a detailed description of this exercise, see Appendix C.)

Organizational redesign can have important positive consequences for the organization and for its staff. After the exercise was carried out at one institution, a unit supervisor made the following comments:

> Getting back to negotiations, the thing that was the most difficult for me was to get used to the idea that the preconceived roles that I had for myself and for my job and for other people's jobs didn't necessarily have to exist. The HIRI people spent a great deal of energy trying to convince us that we didn't have to accept the roles that we had been locked into. I find now that since we started doing things that they told us, my job--I think I can speak for most people--is much more fulfilling, I am a child care worker, but now I'm also involved in

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contact with parents and parents' group therapy. Social workers in our cottage are now involved in day-to-day child care. I have administrative decisions that I'm allowed to participate in. So, for me, the negotiations were hard in that I had to realize that I didn't have to accept the role that I was in--that I could negotiate for other responsibilities, things that were more rewarding for me. It's paid off.

We are not suggesting that an institution should attempt to duplicate the exercise described in Appendix C. The exercise was developed experimentally and was conducted at two institutions, with considerable success, but only after careful planning and implementation by outside consultants. The exercise was not nearly as effective at a third institution because of grave problems in the institution's management and staff. (There was some progress made in its short-term outcome; but a radical change in personnel prevented assessment of its outcome over the long term.) The exercise may be of interest, however, because it provides further orientation to the process of organizational redesign.

3. Filling new staff positions.

Sometimes organizational redesign may create new staff positions. Such positions may result from new combinations of functions formerly included in old positions or may be made up of newly-identified responsibilities. Management might want to encourage staff participation in defining the new job and hiring a person to fill it, because such participation will strengthen their support for the job and the person.

One institution planned and implemented an open hiring process in the following manner:

a. The staff negotiated ground rules for their participation with the institution's associate director, resulting in the following steps.

b. The staff discussed the general requirements for the new job role and listed those they could agree upon.

c. The requirements were posted so that everyone in the agency could see them.

d. Anyone who felt qualified could apply by writing a letter to the participating staff group stating his qualifications in relation to those posted for the job.

e. The staff group discussed each such applicant and analyzed his qualifications in terms of the job requirements.

f. The associate director, after receiving the staff group's recommendations, and after meeting with each applicant reached a final decision about hiring the applicant. He responded to each application by writing a letter giving his perceptions of the applicant's qualifications as they related to the requirements of the job.

Thus, each applicant was hired or received a letter stating in what ways his qualifications were not sufficient and what he might do to become eligible. In one instance, the associate director gave an applicant up to 3 months to satisfy certain requirements and held the job open for her until she did.

B. Delegating Responsibility and Authority.

Delegation never is total. For example, institutional managers must retain authority to make decisions about policy at the institutional level, such as decisions about organizational goals, and the tasks that need to be carried out to achieve the goals; about the institution's boundaries and transactions with its environment; and about certain maintenance and support functions such as budgeting and accounting, purchasing, personnel, medical services, etc.

Although a manager may agree not to interfere, his responsibilities usually require that he know what is going on in the institution. His frequent presence as a visitor can serve that purpose, and his visibility to staff and children can be reassuring and supportive--if he conducts himself so that his presence is benign, that is, not interpreted as snooping.

Delegation needs to be clear and contractual in that the person doing the delegation (usually, the director or associate director) binds himself not to interfere, unilaterally. Such contracts need to be observed or a staff may come to feel that they are at the mercy of a capricious and arbitrary authority, with disastrous effects on morale.

> A director felt overburdened because he was involved in making a wide variety of decisions at every level of the institution. Because he could not attend to all of the matters over which he retained control, important decisions were not made or were made by default. A consultant suggested that he identify a purview over which he wanted to maintain control and that he delegate other areas of responsibility and authority to his senior staff.
>
> The director began to meet with the senior staff on a fairly regular basis to discuss issues that were important to the agency. However, he did not make clear their role in the discussions.
>
> At some times, the director acted as participant, stating his point of view or interest in relation to an issue or problem and the group as a whole, with the director acting as an equal, arrived at a conclusion that the director treated as binding.
>
> Subsequently, the group would discuss an issue, and arrive at a conclusion which they regarded as a decision, and which they strongly supported--only to have the director inform them that he regarded their conclusion as a recommendation, and that he was rejecting it.
>
> Increasingly, the group felt that they were being imposed upon by an authority who refused to be bound by agreement, convention or ground rule. They became increasingly frustrated and enraged and unable to work constructively.

Delegation works best when a manager is scrupulous about imposing constraints upon himself after making his delegation. An institution's director speaks of a continuing process of differentiating his own responsibilities from those he has delegated:

> ...we decided what I wanted to do, and [he] (the associate director) decided what he wanted to do, and we argued back and forth. Interestingly enough, we are still arguing, and we have for the past year. And we're still not clear on some tasks. We developed a way of communicating about it. Every once in a while [he] gets ticked off; [he] sends to me a copy of our contract in terms of what he is responsible for, and I react to it. I feel very angry. Sometimes I feel very threatened about the whole thing. In the final analysis, we work through it and we go on from there. So that, essentially, what we have found is that there is a way of one's identifying tasks that need

to be performed; that there is a way of resolving some of the conflicts that come up...once you get them out in the open... At other times it may be the whole staff. I get to moving around in an area that I've always liked to do, been doing it for many years, and at one of the staff meetings a guy says rather quickly that 'It all ain't well.' We go through several uncomfortable moments with the staff wanting to open up, but finally finding out that they really can lay it on the old man--let him know that he's violated the contract, and that he's in areas that are none of his business. I'll continue to do this, I'm sure, but nonetheless, there's a feedback when I step too far out of line.

I learned to live with it (the split in management responsibilities) and, by golly, the decisions were, in fact, a lot better than the ones I had been pushing. I used to like to go into the kitchen and nose around. Also, I worried about the yard. But now that's [his] responsibility. Nevertheless, I still feel ticked off because we have a new lawnmower and I don't really know if we put enough time into thinking about getting the other one fixed! But I'm beginning to find out that if I'm using my time well, I'm not worried about the lawn mower and the yard. I'm keeping an eye on the outside and bringing in information and sharing it on the inside. It's a case of finding a whole bunch of new tasks.

One thing I've found out is that I could no longer do everything in the agency. I began to learn, too, that there were many, many people who do things differently, better, and were hired to do that particular thing. I had to no longer 'lead the way' in every job that came along.

C. Creating Work Groups

A manager has responsibility for creating appropriate work groups that will assume many of the responsibilities necessary to sustain the organization and its programs. Groups may be relatively permanent (such as administrative groups that take care of financial matters, purchasing, housekeeping and planning or operational units concerned with intake) or temporary (such as treatment teams formed to take the responsibility for planning and implementing a treatment program for individual children).

Traditional organizations tend to be reluctant to create new groups or disband old ones; they tend to preserve the prerogatives of existing structures even though group composition may not be appropriate to deal adequately with some new issue. The flexibility to form new work groups, with their own mandates, on an as-needed basis is an important organizational characteristic of an institution that has an open-systems posture. Such groups tend to be maximally concerned with reaching objectives and minimally concerned with distracting political issues. By keeping their boundaries open, they can recruit new members or engage outside resources on an as-needed basis.

In an institution organized as an open system, ad hoc work groups may be formed by staff members. However, managers are more likely to take leadership in convening such groups because their perspective enables them to identify institutional needs that can best be addressed through group efforts. The manager and the group together can decide when to disband it.

> An institution created a temporary task force, led by a professional staff member, to plan for converting the organization of its staff into interdisciplinary treatment teams. The task force was chosen from interested volunteers invited from all of the groups that would be affected by the work of such teams, including social services, institutional administration, the child care staff, teachers, and children.

Work groups should be designed to counteract the splitting, competition and conflict that tends to occur between professional, role and status groups.

> The chairmanship of an interdisciplinary work group was rotated, monthly, in order to minimize the conflict that might occur because of traditional differences in status.

The manager should take pains to make certain that the composition of meeting and work groups is appropriate. Everyone affected by group decisions or actions either should be present or represented in group meetings.

> At one of the first meetings at which the HIRI consultant was present, the social service staff of an institution presented a paper describing a new organization for the social work, child care and teaching staff. They had just distributed that paper to all members of those staffs. However, they had developed the new organization without the participation of either the child care staff or the teachers. Shortly afterward, the teachers complained to the consultant that they would be

> pressured to go along with the new organization even though they objected to some of its provisions and that they would be labeled as "the problem" if they were not acquiescent. At a subsequent meeting with the social workers, the consultant pointed out that they had not involved the child care or teaching staff in formulating their plan and that it likely would be met with resistance. He suggested that the plan would more likely be successfully implemented if the work group developing it contained representatives of all of the groups that would be affected by it. The social service staff arranged a new meeting to include the child care workers and teachers in order to prepare a new plan.

D. Staff Development and the Use of Outside Resources

When decision making is decentralized the need for well planned and carefully executed staff development increases. The staff is asked to take on many kinds of decisions which heretofore have been made by management. In addition, if treatment is being administered by teams, many staff members will be called upon to play entirely new roles vis-à-vis each other and the children. Specialized training for these new responsibilities is always advisable.

Initiating this staff development program is a management responsibility. In the model we are describing in this section, implementing the program, on the other hand, was successfully delegated to a staff development group designated by management but assuming their responsibilities with general consensus within the staff. From that point on, although the committee was ultimately accountable to management, it functioned with a great deal of autonomy. There was two-way communication between the committee and management, support from management when additional resources were necessary but as little interference as possible from management.

> At one institution the responsibility for a staff development and training committee was assigned by the administration to one of the unit supervisors. The HIRI consultant worked with this committee in a variety of ways, providing support to the committee chairman, to the committee functioning as a group, and to subcommittees. He served as a resource person particularly in helping them identify and obtain outside consultants. He also provided feedback so that the committee could benefit by ongoing evaluation.
>
> Once the committee was established specific needs were pinpointed (both through agency-wide and internal committee

discussions) and subcommittees were established to deal with those specific needs--for instance, agency technology, interpersonal processes, communications.

It was determined that for every identified training need outside resources needed to be called upon. As a result, a number of consultants were utilized by the committee, usually for 1-day workshops or comparable "special events." These workshops included one on communication, one on parenting and one on goal setting. In addition, the HIRI project consultant himself* served as a resource for ongoing staff work on self-disclosure based on Jourard's work (1968).

The foregoing vignette highlights the crucial role played by outside resources in a staff development program. The four CRCs involved in our project had available as an outside resource an organizational consultant meeting with them over a period of a year who addressed himself, among other issues, to the problems of staff development. This is, however, an atypical situation. Given the limited resources with which most CRCs work, both in terms of money and manpower, a staff development committee can be informed, discriminating and aggressive in identifying outside consultants who can help them solve specific problems and in indoctrinating their fellow staff members to accept such consultation openmindedly and to put it to use productively.

Generalizing from our experience with the CRCs involved in this project, we suggest the following steps as a model for implementation of a staff development program:

1. Identification of need

   Although a staff development committee has responsibility for the total program, the identification of training needs should involve the entire staff. Staff should be called upon not only to articulate needs, but also to help the committee to establish priorities.

2. Establishing contract with consultants

   Many CRCs have had only limited experience with the use of consultation--primarily with case consultation or consultation to staff regarding behavior of individual children. Since they will in a sense be in totally new territory in dealing with the range of consultants who might be called in for staff development, it is suggested that the relationship with each consultant

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(no matter how limited the time of the relationship may be) be defined by a contract, either written or oral. This contract should reflect an agreement by both parties concerning:

a. the problem or opportunity to be addressed

b. the desired outcome

c. the value of that outcome to the agency's effectiveness

d. the specific intervention tactics to be used

3. Prepare the staff for the event

Many segments of the staff development program will be isolated events such as the specific workshops alluded to above. It is a familiar hazard in dealing with such events to have a skilled consultant arrive on the scene, deliver his riches and depart without the staff really knowing what happened. The staff and sometimes the consultant need to be primed for the occasion. The staff development committee might concern itself with questions like:

a. How can the committee best prepare the staff for this experience? Through preparatory discussions at team meetings? Through direct participation in planning? Through information dissemination?

b. How can staff be motivated to a high level of interest in the upcoming event?

c. What information should be communicated to the outside consultant so that his presentation will best fit our needs?

4. Planning the event as a founding experience

There are, of course, limitations to how much information can be imparted in a 1-day workshop or conference. However, if the staff development committee makes clear that the specific event is essentially a founding experience, it will be so perceived by the staff. That is, the event itself is expected to serve the purpose of stimulating ideas and introducing new skills. Instant mastery of those skills is not expected nor is it usual for the ideas introduced to take hold immediately and catapult the institution into profound change. A major task of the committee, therefore, is to extend the input of the time-limited workshop or conference, keep the staff interested in what was introduced, link it to other experiences they are having and determine when they are ready for new input from a different consultant.

5. Evaluation of the event

Evaluation of a specific training event can be little more than descriptive but cumulatively these evaluations will provide guidance to the staff development committee. Such assessments can be carried out by questionnaires, by informal discussions and by feedback at staff meetings. In most instances, it is productive to ask the consultant himself to contribute to the evaluation.

The use of outside resources on a short-term basis can help the CRC staff develop its treatment skills as well as skills in management and coordination. Ideally, the staff ultimately develops an awareness of themselves as resources to one another, particularly in issues such as communications and interpersonal skills.

A staff development and training committee can play a crucial role in enabling a CRC to function both as an open system and also as a learning system. The committee operates on the boundary of the institution, identifies staff learning needs and appropriate outside resources that can satisfy those needs, and plans programs to bring together institutional staff and resources in a manner that will enable learning to take place. As it gains experience, a committee may improve its ability to reach out into the environment, to help a staff make desirable changes on a continuing basis. The environment contains a multitude of such possibilities in addition to expert consultants: reports of research and innovative programs, representatives of agencies at which interesting programs are being carried out, opportunities to visit or train at other settings, opportunities to invite visits from staff members of other agencies. A staff development and training committee is an important structure that links an institution's staff to the world of research and innovation and sustains a CRC's ability to learn to improve its effectiveness.

E. Reviewing Procedures and Processes

The systemic nature of CRCs extends to the interrelatedness of the ways in which work is done and the results of the work. Especially, when a CRC has a mission that requires individualized treatment, it is not likely that it can be achieved unless its procedures and processes are consistent with its objectives. Two kinds of consistency need to be considered. The more obvious is operational--that is, that the formal design of an activity, the sequence of operations of which it consists should make it capable of producing a desired result. In this section, we discuss another kind of consistency--that the qualitative characteristics of activities, the values they imply, should be consistent with their objectives, in particular the treatment objectives to which we have been referring.

Work groups and line personnel often are not reflective about the values expressed by their procedures and processes. They are used because of expediency, or familarity or because of other reasons not associated with treatment objectives. However, they have considerable potential for influencing the relationships between staff members and between the staff and the children. If an institution's rhetoric professes one set of values but if, in fact, its procedures embody another set, it is likely that the children ultimately will be more influenced by the reality of the procedures than by the rhetoric.

> A consultant attended a meeting of the principal of an on-grounds school and the certificated teachers assigned to the school from the local school district. During the meeting, the group made decisions about the assignment of children to classes that would affect a number of non-certificated teachers (primarily special activity and shop teachers) who were not present. The consultant pointed out that the group which was present was making decisions for and about the group that was absent and asked what this would imply for the working relationships between all teachers during the remainder of the school year. The consultant also pointed out that the procedure was contrary to a goal-setting procedure that was being adopted by the school in which children were to participate in establishing their own educational goal. The consultant asked the group to consider whether there should not be consistency between the work norms of the teacher group and the values represented by the new goal-setting procedure.

The director and associate director within a children's residential center have the most awareness of the implications of the institution's mission and the best vantage point from which they can view its workings in terms of that mission. They may choose to review the institution's procedures in terms of its mission personally, or may want to delegate that responsibility to some perceptive staff person who is capable of adopting the necessary perspective.

As part of that review, they might well consider the procedures used by staff in the child-caring process. Sometimes a procedure is adopted for the convenience of the staff that has implications that are contrary to the values embodied in the institution's program.

> The teachers of an on-campus school had been feuding with the child care staff about children's misbehavior while at school. The teachers wanted to provide incentives for the children's good behavior by using a point system; when a child had amassed a certain number of points he would be able to buy desirable things at the institution's commissary. The teachers devised a card that each child would carry with him, both to school and to his living unit. Both staffs would make notations on it about his behavior. Presumably the card would become a means for keeping a written record about the child's behavior. However, the card also permitted the feuding staffs to pass messages without having to talk together. Furthermore, the card would become a vehicle for making decisions about a child's reward *bureaucratically*; whether he should get his reward or not would be decided by the number of points he earned on his card rather than by a decision made by people that would take account of the child's individual needs. The consultant pointed out that the "message" that would be implied by using the card would run contrary to everything the institution wanted to stand for--human values, and a high regard for communication and interpersonal relationships as a way of dealing with human problems.

A manager should be sensitive to the implications of his own administrative procedures. Many institutions tend to use memoranda to announce policies and decisions--in effect, legislating decisions for staffs which have not been involved in their formulation. The leadership of an institution whose primary task is the delivery of individualized treatment services should ponder the impact of such procedures on the staff relationships that are supposed to be a model for the children. For example, if an institution's treatment philosophy is humanistic, but if the director is authoritarian (for example, uses written directives to announce his decisions); if staff decisions are made according to "the book" instead of in terms of the particulars of individual needs; if the staff uses memoranda to communicate instead of personal contact, discussion and negotiation, the institution would be behaving contrary to the humanistic values of treatment. The "message" of the real life relationships would contradict the thrust of treatment and might sabotage it.

By setting an example in the administrative procedures he uses, a manager may have a salutary effect on a treatment program. Staff may become more sensitized to the implications of their child management methods.

> An institution was planning to buy new bedspreads and drapes for the children's living units. A consultant pointed out that

the way in which the fabrics were chosen could have meaningful implications for treatment: deciding *for* the children would have a different impact than involving the children in the decision-making process. Doing the latter would provide an opportunity for children to learn important skills for working with others in a group, discussing issues and negotiating compromises.

X. Managerial Style

In this chapter, we discuss the style of management that seems most appropriate for a decentralized children's residential center. Greater reliance on the discretionary decision-making authority of staff throughout the institution has important implications for the style of managers. Clearly, different organizational structures require different managerial stances.

> ...It is important to recognize that the organic and growth concepts of organizations imply that at different stages of growth, different kinds of structure and managerial leadership might be appropriate. In the early stages of an organization, some degree of autocracy may be appropriate, while it might be inappropriate at the later stages of uniqueness and maturity. It is also relevant to point out that as different crises emerge in an organization and the organization is confronted with a recession, competition or waning interest in its service, it may need to revert to different styles of management to "see it through" a particular period of its life. (Lippitt, 1973, p. 60)

A. Establishing Credibility

Because the ties between a decentralized institution's director and his staff are less administrative and supervisorial than in traditional organizations, and because the relationship is less one of control through coercion, leadership tends to replace the use of direction as the appropriate style. Traditional power gives way to authority based on recognized competence. Although a director's authority may originate in an institution's board of trustees or some superordinate body, ultimately his effective authority will depend upon his competence as recognized by the staff. As they recognize that competence, they will vest authority in him to exercise certain leadership functions on their behalf--to manage the institution's boundaries and its relationship with its environment; to define the institution's goals and tasks; and to delegate responsibility and authority. Thus, the director (and associate director) and anyone playing a quasi-directorial role needs to adopt a style that is consistent with a decentralized organization.

Relations with managers (especially the director) are often viewed as the model for relationships among the staff members and between staff members and children and (ultimately) among children.

For example, if an institution wants its treatment staff to work in interdisciplinary teams in which decision making is participative, a hierarchical relationship between the director and his immediate associates would be inconsistent.

Directors can maintain their credibility by making it clear that their activities are meant to support staff activities.

> The staff of one institution in part believed that the director was indifferent about their efforts, because of his apparent willingness to invest considerable sums of money in expensive office equipment and his reluctance to allocate money to living units for program-related activities.

Directors can demonstrate their sense of priorities in rather simple and direct ways.

> The director of an institution (not in our sample) makes certain that he lunches with the children, at their tables, several times a week in order to make himself visible and available and to have relaxed conversations with the children and the staff.

B. Encouraging Staff Autonomy

Managers' styles--whether they be directors or middle managers--should help develop the capability of staff members to make decisions. Their styles should discourage dependency and encourage the taking of responsibility. They do so when they focus on issues and share problems, rather than offer solutions; when they encourage staff to set objectives, and plan to reach the objectives; and when they offer to provide resources to help the staff do so.

Under some circumstances, especially when there has been a history of staff-management conflict, managers might need to take special pains to avoid making communications that the staff can construe as dictatorial mandates. A staff which is uneasy about having responsibility for making decisions and acting with greater independence than usual might *need* to view a director's statements as pronouncements.

> In one institution, staff tended to regard the director's statements and memoranda as mandates, even though the director intended otherwise. A consultant inferred that many staff members felt uneasy about taking responsibility and assuming the initiative in areas in which they only recently had been delegated responsibility. He speculated that they might *prefer*

> to believe that a director was being dictatorial because they could then rationalize not asserting themselves--which might bring them into conflict with him or with each other. The consultant suggested that the director take care to avoid behaving in a way that would enable the staff to distort his intentions. Thus, he might avoid suggesting solutions but, instead, share problems. Instead of writing memoranda making suggestions to the staff about possible solutions, he might meet with them and (in effect) say, "I have a problem that I want to tell you about...I am concerned about it in the following ways...I hope you can help me with that problem...Your recommendations will need to take into account the following constraints... I hope you can suggest something by the following date." The consultant suggested that the director take care to be specific about whether he wanted a recommendation or a decision. If the staff was unclear and mistakenly believed they were making a decision when the director wanted a recommendation, they might use his refusal to accept their "decision" as proof that he was, after all, being dictatorial.

C. Directness of Communications

The greater the extent of staff participation in decision making, the greater their need for reliable information so that they can use their discretionary authority in an informed manner. The staff of any institution is dependent upon management for much of its information. In a decentralized institution, managers should be aware of staff needs for information and should take pains to be clear in their communications.

> An institution's director characteristically expressed himself with subtlety, indirection and irony. Some could appreciate his subtlety and appeared to understand him most of the time. Most of his staff, however, often were undecided about his intentions and had long discussions among themselves, debating about what he meant.
>
> During the HIRI consultation, a consultant suggested that the institution consider an exercise that would help them clarify and redistribute responsibility among the staff. After some discussion, many staff members came to support this proposal and urged the director to agree to the exercise and to bind himself to the results of its outcome.
>
> Although the ground rules of the exercise permitted a director to state constraints and conditions that would limit the range

of possible outcomes, to some extent, within those limits, the outcome would be unpredictable. Thus, the exercise entailed some risks, although they were minimal. The director understandably was hesitant. Clearly, he needed more information in order to make an informed decision about whether to proceed.

The director and a group of staff members met to decide whether to proceed with planning the exercise. During the discussion, the director expressed himself ambiguously regarding his intentions. No decision was reached. The staff left the meeting feeling agitated and angry. Many staff members felt that the director was being evasive in order to set the stage for not committing himself to the outcome of the exercise. They speculated that he was going to agree, reluctantly, to proceed with it and then find reasons not to implement it.

If, during the meeting, the director had openly expressed his feelings of uneasiness, uncertainty and unwillingness to commit himself to the outcome of an event he did not fully understand and if he had stated his intentions to get more information before deciding, the staff likely could have accepted his hesitance without ill will. They likely would have understood that it was unreasonable to insist that the director commit himself to a course of action whose consequences he did not understand.

D. Providing Adequate Information

Because the director of a children's residential center that is decentralized and operates as an open system involves himself primarily with the interface between the institution and its environment, he may appear to the staff not to be concerned with the work being done at the child care level. He may need to make special efforts to inform the staff about his activities and about their function in maintaining an institutional context in which the staff can carry out the tasks related to child care and treatment--which he considers the most important activities in the institution.

A director was very much involved with efforts to improve state statutes related to the financing of children's institutions, with negotiating with counties regarding their payment rates for children they referred, and with his board of trustees in planning a group home to extend his institution's range of services. His staff was not informed about the relationship between his activities and increasing the institution's potential for providing services. They did not relate his activities to his commitment to preserve the institution and to support them in carrying out their activities. They developed a belief that he was interested in running the institution as a business. Some developed a reciprocal attitude of indifference toward the well-being of the institution as a whole and expressed that feeling by neglecting the upkeep of the physical plant.

XI. Organizational Integration: A Priority Task of Management in a Decentralized Organization

Traditional organizations achieve integration through their hierarchical structure, the activities of supervision, and the design of work as an interlocking series of tasks. Decentralized organizations, however, have abandoned--at least in part--some traditional forms of organizational control, and have special difficulty maintaining integrated action.

A priority function of management in decentralized organizations is to create and implement special integrative measures. Following are some of the characteristic measures used to tie decentralized institutions together:

1. Organizational system building.

    Managers create integrating work groups and teams for the purpose of planning, information sharing and coordinating the activities of the different work groups team members represent. Treatment teams, living units, the on-campus school, the recreation workers, etc. send representatives to meet with a coordinating manager (usually the associate director) to help integrate the institution horizontally. Institutional management meets with service-delivering work groups to integrate the institution vertically. Staff roles are defined so that they contain responsibilities for linking or coordinating activities both horizontally and vertically. Formal accountability procedures are one way of integrating the institution vertically.

2. The use of information.

    The institutional director can formulate and state institutional definitions of mission to direct the attention of staff members to their common purposes. Changing circumstances, either in the environment or internally, require that the director restate or re-interpret mission in terms of implications of the change. Management can use its access to channels of communication to create shared frames of reference. Managers can interpret the changing environment and the place of the institution in it. Their perspective enables them to present the staff with an integrated picture of the institution as it is operating internally. Information is one of the most important tools available to leaders in building their own credibility. The credibility of leadership, itself, is an integrating force.

3. Maintaining the institution's focus on its primary task.

> Management, by its allocation of priorities, use of budget and use of personal influence focuses the attention of the staff on the institution's core process--the child caring and treatment tasks everyone is there to perform or support.

Both organizational structural realities and the impact of leadership mold and influence staff behavior so that staff integrates its efforts in achieving goals implied by the organization's mission. (Olmstead, 1971, p. 125)

The following presentation describes in somewhat greater detail some measures a decentralized institution can employ to improve functional integration.

A. Horizontal Integration with Living Units

The interdisciplinary treatment team which brings together every significant staff person working with a child for information exchange in frequent, usually daily, formal and informal meetings provides a good basis for integrating staff at the service delivery level. When services were provided by staff members who came to units from different departments, and when those staff members usually coordinated their activities with supervisors within their own departments, coordination between staff members providing services to the same child often was poor. (Gold & Mihic, 1971, pp. 13-20; Sternbach & Pincus, 1970, pp. 327-335)

B. Horizontal Integration among Subsystems

Although decentralization into teams increases opportunities for coordination among those who provide direct services to a child, it decreases the integrated functioning of subsystems (living units, the on-campus school, institutional management).

> Overall programming at one institution became uncoordinated because there was little attempt to relate the activities of the several living groups. The managers of those groups preferred to work independently of one another. There were no scheduled meetings to bring them together on a regular basis. The staff person who nominally was their supervisor was reluctant to assume responsibility for integrating their activities, at least partly because of their resistance to his efforts to impose constraints upon their authority. A consultant suggested that they might find it advantageous

to meet because the institution's director was becoming very impatient with their lack of coordination and resulting lack of accountability--in particular, for maintaining the institution's population at an acceptable level. By meeting, they might be able to agree upon ways in which they could coordinate their activities so that the population level could be maintained while infringing as little as possible upon their autonomy.

When a children's residential center is decentralized, the manager responsible for internal management can support institutional integration by scheduling regular meetings of second level managers--unit supervisors, the school principal, professionals responsible for treatment programs, supervisors of special programs (like recreation). At such meetings they can discuss plans, identify needs for further coordination and resolved differences. The manager can use such meetings to integrate the activities of relatively autonomous work groups (horizontal integration), to keep himself informed of their activities and to make certain that their plans have taken into account institutional policies and the interests of management (vertical integration).

C. Vertical Integratic

Vertical integration--between the service-providing level and institutional management--is relatively easy to maintain in a traditional organization by virtue of its hierarchical nature and levels of supervision. However, in a decentralized organization, the institution's manager needs to plan to maintain vertical integration.

In most organizations, such as manufacturing enterprises, the main business of the organization, its "core process"* is guided by top management. Operating units responsible for production would be unable to proceed without daily guidance from top management based upon their contact with suppliers, consumers and other components in the environment.

In children's residential centers (and other service-providing agencies), however, operating personnel (those providing direct services) themselves are in contact with suppliers (representatives of referring agencies), consumers (their clients), and other important environmental determinants of their activities. Other environmental groups which ultimately need to be taken into account (funding sources, regulatory agencies, boards of trustees, community groups, etc.) *seem* more remote unless immediately important in transacting the day-to-day business of treatment. The director, who is responsible for maintaining relations with these latter groups, may also seem remote because he may appear not to be directly involved with matters that are important to the core process being carried out by the treatment personnel.

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* The core process is the set of central transformations an organization undertakes to carry out its basic purposes. In a manufacturing enterprise, for example, the core process includes the assembly line and all activities directly related to the creation of the product.

As a consequence, unless institutional managers (perhaps in particular the associate director) plan integrating links, they may drift out of touch with the operating level. It is easy for program staff to lose perspective about the importance of the maintenance and support functions unless managers keep them informed about these activities and their relevance to the child care and treatment process.

Similarly, managers who are concerned with environmental, budgetary, personnel, plant maintenance, licensing and other similar matters, may lose awareness of the realities of the treatment program. Managers need information from those responsible for treatment in order to coordinate organizational efforts, to plan, to acquire and allocate resources, and to do staff development. Similarly, program staff need help with their planning by being informed about the current and future availability of resources, referrals and long-term institutional planning.

Managers need to schedule meetings to maintain vertical integration between those engaged in the institution's core process and the managers and administrators who are responsible for maintaining the institutional setting in which program activities are carried out.

The following example illustrates how an institution can structure meetings selectively geared to decision making and information sharing as integrating processes.

> The director and senior treatment staff of one institution reviewed and analyzed the recent history of their weekly administrative staff meeting. They discovered that the agendas were cluttered with items in three categories--administration, treatment program and trivia. The director recently had assumed responsibility for the agency's relationship with its environment and for overall administration, and had ceded responsibility for internal operations and the treatment program to an associate director.

The director, therefore, needed to meet occasionally with the senior staff to discuss administrative matters and wanted to be kept informed about what was going on in the agency's treatment program. He needed that information in order to represent the agency in its environment and to be able to plan for the future. On their part, the associate director and senior treatment staff needed to be informed about administrative matters and needed to meet regularly to discuss issues having to do with the treatment program.

All of these needs were met by restructuring the meetings. The director would chair an administrative staff meeting at least once a month; additional meetings might be scheduled on an as-needed basis. The associate director would chair meetings about the treatment program on a twice-monthly basis; the director would participate as a member of the meeting group, would have access to information he needed but would have no special authority in that group. In this manner, meetings were structured to provide for opportunities to make decisions in both areas and to share information as needed. The appropriate director had leadership of that meeting which made decisions about matters under his purview and both directors had the opportunity to share and acquire information in the area of operations that was within the other's purview.

D. Vertical Integration and Management Conferences

From time to time, the director may arrange a management conference. Conferences are general meetings which should include all of an institution's staff. Conferences are not held to produce decisions; the number of interest groups and the larger number of people in attendance preclude orderly and binding decision making for the most part. However, the open discussion of issues and problems may provide information that is needed in order to make decisions at later, smaller, more structured meetings. Conferences are particularly useful to determine whether existing policies are understood consistently throughout an institution, to solicit new ideas for making improvements, to test group consensus, to permit the organization-as-a-whole to examine itself to see if it is behaving in an integrated and effective manner and to identify areas in which it might try to improve. At management conferences the director can provide the staff with information about the institution's environment--how the institution is doing in relation to community expectations.

During conferences, managers can introduce new policies so that everyone in the organization hears the same thing at the same time and can clarify ambiguities. These new policies may have been formulated as a result of issues raised during previous conferences. A staff task force may have been formed to explore such issues and may have been delegated the responsibility for making a recommendation or decision which then is presented to the organization in the follow-up management conference. Management can use such conferences to get everyone on board.

Management conferences which include the entire staff are opportune occasions for the director and associate director to ask, "How are we doing?" and to present information that they have about the institution, its processes and its performance--from the perspective of the outside and inside managers.

The institutional managers may prepare for such conferences by having meetings with groups of staff members to develop a picture of operations and/or may administer a questionnaire to poll staff opinion. One such questionnaire, the Institutional Self-Study Questionnaire was developed in the course of the HIRI project (see Appendix B, Section A). It enables an institution to aggregate staff members' opinions about various areas of institutional functioning, and thus provides a means for periodically identifying those areas in which the staff members feel the institution needs to improve itself.

During the discussion the managers and staff can identify issues on which the institution needs to focus special attention and can take steps to create new, special task-oriented groups to address those issues.

At management conferences, the director has a unique opportunity to talk to the staff about himself, about what he is doing, about the directions in which he is moving, about how he is representing their interests, and about how he views the future. Because he is the boundary manager, he is in danger of becoming isolated from the institution's staff. It is important that he use opportunities to make himself visible and known to the staff in order to prevent the formation of projections and myths which grow so easily about those in authority in an organization. His frank talk and openness can be a good antidote for the irrationality that is latent in every organization.

E. Limits to Meetings as an Organizational Tool

Meetings tend to be effective in the degree to which they have purpose and direction. If meetings' objectives are not clear--whether the participants are meeting to discuss, meeting to decide, meeting to listen--it is easy for them to take place without serving the purposes of work.

The expense to an institution of just a few hours a week spent by numbers of staff members in meetings can be considerable. Managers may want to perform a review of meetings, periodically. A preliminary step is to review, with staff members, the existing pattern of meetings in order to make certain that they are functional. Typically, institutions, over a period of time, schedule meetings which once might have been functional but which have become outdated as work patterns change. A careful review of the existing pattern of meetings, to test each one in terms of its contribution to the program, whether its participants are appropriate to what the meeting is expected to accomplish and whether, in fact, it does accomplish those objectives, may reveal that some meetings occur on a regular basis that are strictly ceremonial in nature. The manager might want to review with staff the cost of existing meetings in terms of the cost of the time of staff members who regularly attend. He may be able, through such a review, to more carefully select participants or do away with some meetings which have marginal utility.

A manager can help teach the staff to employ written agenda with objectives written for each agenda item (what its sponsor wants to come out of the meeting with) and to use minutes to record decisions (especially those in which individuals and groups commit themselves to action) and which specify a date for a report back to the meeting group about the progress that has been made.

> A consultant prepared a checklist for a meeting group that met regularly, containing items that refer to group processes such as level of communication, agenda items covered adequately, purposes of meeting met, etc. Periodically, when he was present at the meeting, the consultant would review the members' own evaluation of their meetings in order to report trends to the group.

Etzioni (1960, pp. 13-22) cautions that conferences and meetings that purport to be occasions for participative decision making can be empty of their intended meaning. Unless good working relations exist, unless relations are, characteristically, egalitarian and interpersonal relations are open, such meetings can become sham occasions for managers to manipulate the staff. Instead of encouraging discussion and upward communication of staff opinion and information, managers can exploit such meetings to reinforce the imposition of authority. The resulting hypocrisy will be apparent to the staff and will make bad situations worse.

F. Using Information Channels to Integrate Staff Action with Mission

The director's control over channels of information is one of the most important tools he has in integrating staff effort in working toward the goals implied by institutional mission. First, the director is the authoritative source of definitions of mission and can provide all staff members with access to those definitions--through participation in their formulation, through meetings and discussion of their meaning and implication once they have been formulated, and through written statements which he can disseminate through the institution. Second, because he can designate the channels of information flow (particularly about children) that the institution officially recognizes, the director can identify the individuals and role groups who are to have leadership. Giving the right group control over information channels becomes especially important when an institution's mission encompasses more than one primary task and when those primary tasks are in competition or conflict. For example, when institutions are in transition from an educational, work-centered, custodial or simple child care mission toward a mission that requires individualized treatment, a director facilitates movement toward the new mission by delegating responsibility for communications about children to the treatment staff. (McCleery, 1964, pp. 387-389)

G. Job Descriptions as Integrating Devices

Managers can facilitate staff integration by the way in which they define jobs. Formal job descriptions can have an important influence on staff members. Defining a job in terms of the responsibilities it encompasses helps staff members maintain a focus on the contribution of their own activities to achieving an institution's mission. A description of responsibilities links a job to institutional mission because it helps a staff member guide his activities in terms of the job's purposes. In most cases, the link between responsibilities, purpose and mission will be self-evident. Where it is not, a job description can state that relationship.

> A social worker's job described in terms of purpose might read: Responsible for designating appropriate treatment goals, developing relevant treatment procedures and supervising the implementation of those procedures so that a child can benefit enough from treatment experiences to be returned to his community within a year.

The description focuses on the core of the job rather than the activities it may include. Because the goals are stated explicitly, the staff member (and the person to whom he is accountable) can assess his performance in achieving those goals.

When a job description consists of a list of specific duties and tasks, it is shallow in that it describes the job without relating it to the agency's mission or the roles of other staff members with which it is, in fact, interrelated. A shallow description leads a staff member to think of his job as a set of activities, rather than as activities that fit in with the institution's purpose. He may view his job in a segmented manner. Such a job description does not help him use his judgment in order to perform his duties in a manner that contributes to the institution's mission.

> The same social work job, defined in terms of activities, might read: Does individual and group psychotherapy; meets regularly with unit staff; maintains contact with family members.

Given this latter job description, a staff member might lose sight of the relationship between his activities and the institution's mission. In extreme cases, a staff member might consider that he is doing his job if he conducts a certain number of activities during a week, regardless of their contribution to the institution's mission.

A functionally useful job description also serves to integrate the job with other jobs, and describes the relationships between job holders.

> 1. To understand and predict a man's behavior on the job, we must ask to what other jobs his is connected (to what other persons is he connected, and what is the nature of the connecting bonds--formal authority, personal liking, task interdependence, and the like).
>
> 2. To change the behavior of an individual or the content of a job involves complementary change on the part of all the "bond holders," the people to whom he is directly connected in the organization...(Kahn, 1964, p. 389)

Kahn also points out that an individual and all of those with whom his job is interconnected should meet periodically to clarify the expectations they have of one another and the ways in which their jobs interrelate.

Describing a job in terms of responsibilities and in terms of the other jobs with which it is interrelated enables staff members to negotiate the sharing and dividing of responsibilities. Doing so should provide staff integration and should reduce the likelihood that some responsibilities will go untended.

Appendix B is a handy worksheet designed by one of the HIRI project consultants*, illustrating how one responsibility can be explicitly identified, described and delegated.

H. Some Consequences of Improved Organization Integration

The workshop described in Appendix C ultimately (after a month or two of follow-up staff work) resulted in an improved organizational design, new descriptions of staff roles in terms of responsibilities and a list of "Meetings Necessary to Carry Out Responsibilities of Agency" (See Appendix C, p. 123 for details, as described by the consultant) that appeared to improve staff effectiveness and integration.

Several months later, an independent evaluator summarized staff reactions:

> Previously, people "worked here" but the expectations, the scope, the authority weren't defined. They were now utilizing meetings much better than before. They had agendas. Things were a lot more "up front"; problems which came up weren't suppressed; they didn't "go underground" any more.
>
> The unit supervisors no longer slipped out of meetings and other obligations. Things happened at the meetings and people wanted to have a part in them. Since responsibilities were clear, no one wasted much time trying to shirk them. They felt that they were attending more and more meetings, but that the meetings were better. Having the meetings set up weekly on a calendar helped the staff plan their time better. The board of directors began to meet with them. They were consulted on matters, and this was not true before. People now listened to the cottage staff.

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* Robert L. Blinkenberg

XII. Summary

Like any organization, a CRC must organize its staff to perform those tasks required by its mission. This document describes organizational considerations that appear important in agencies whose mission involves providing residential treatment services to children.

In the course of a 3-year, OCD-funded project, HIRI offered organizational consultation to four CRCs, all of which were attempting to furnish improved treatment services during the shortest possible period of institutional placement and at the lowest possible cost. All were moving toward individualizing treatment and were trying to become more effectively interdependent with and responsive to the expectations of the communities they served. The HIRI consultants became involved with their institutions' efforts to develop the new organizational capabilities required to achieve these objectives. This document presents insights about the organization of CRCs--gained in the course of the consultation experience--as they may be of interest and useful to institutional managers.

First, the organization of the institutions needed to change to enable greater individualization of treatment. These CRCs already had adopted a strategy of organizational decentralization to enable them to individualize treatment, and were at various stages of implementing that strategy. Decentralization involves delegating responsibility and authority for decision making about individual children to operational staff members who are directly involved with the children. Decentralization is an appropriate strategy because it increases flexibility of decision making, permits planning to minimize crises with individuals and groups, and is condusive to a staff's ability to learn from experience because those who plan, do. Our consultants tried to help the institutions (re)organize their staffs to implement the strategy of decentralization.

Second, to maximize integration with and responsiveness to their environments, our consultants helped the CRCs change organizationally so that they could function as open systems. Organizing a CRC as an open system should increase its responsiveness to community expectations that it treat children effectively, in the shortest possible period by facilitating the admission of children, their effective treatment within the institution and their movement from the institution into placement back into the environment. A CRC may function as a learning system (one variety of open system) by creating a staff group to assess organizational effectiveness, (primarily, in treatment) to determine needs for improvement (in systems and skills), to develop programs to make desirable changes and and (when necessary) to engage outside resources in such programs. The staff group takes responsibility for planning to utilize those resources effectively and for following through in a sustained effort to introduce change and improvement.

Decentralizing decision making in a children's residential center provides a special opportunity for integrating staff efforts within living units. One organizational vehicle designed for that purpose is the interdisciplinary team, made up of professionals, child care workers, teachers, a child, his parents, representatives of referring agencies (and others directly concerned with the child's welfare). The team plans and implements a coordinated, goal-oriented treatment program to help the child progress toward his treatment goals. The treatment team focuses resourses at the level of care and integrates the efforts of all of those who are important to effective treatment--overcoming the horizontal fragmentation that typically occurs in traditional organizations in which members of different professional role groups each tend to offer services in isolation from the others.

Although treatment teams have distinct advantages, their effective action requires special flexibility and expertise on the part of staff members. Professionals become more involved within living units than they have been before. In some decentralized institutions which employ treatment teams, child care workers become primary purveyors of treatment services. Child care workers need to develop new expertise to make important decisions about children and to participate effectively on the team and in the treatment process.

The CRCs to which we provided consultation clearly demonstrated that institutions should proceed cautiously with decentralization and team treatment by using a planned process of staff development and training. At each step managers can assess their staff's ability to deal with new responsibilities before proceeding further.

Decentralization can create organizational difficulties. In particular, because vertical integration--which, in traditional organizations is maintained by supervision--is loosened, living units and other functional groups become more autonomous both from management and from each other. They may tend to run independently, with different policies, poor coordination, and unproductive competition for resources. Differences in objectives may make it difficult for managers to evaluate their effectiveness. Some directors have difficulty with decentralization because it requires delegating more authority than they are comfortable doing.

In a decentralized organization that is designed to operate as an open/learning system, institutional directors need to take on new roles and responsibilities. Because they have delegated (most of) the responsibility for making decisions about individual children, they direct less and manage more. Their new role emphasizes the management of transactions across the institution's boundary and system design and maintenance.

By managing his institution's boundary functions, a director can develop its adaptability and responsiveness as an open system. The director assumes responsibility for such activities as: developing (and updating) institutional definitions--statements of institutional purpose that guide both the community and the institution's staff; interpreting the institution to the community and the community to the institution; negotiating for resources and support; maintaining a relationship with a policy-making board; developing new community projects; providing consultation to community groups; planning the institution's role in relation to the community, over the long term.

In any organization, managers have responsibility for designing a system to perform the tasks required by the organization's mission. The HIRI consultants worked to strengthen (or create) their client-institutions' organizational capability for providing individualized treatment. They developed and implemented an exercise to support managerial (and staff) efforts to review organizational design in relation to mission, to make indicated changes and to build competence to make further desirable changes in the future.

The consultants also helped their institutions' management increase organizational integration (to overcome the disintegrative consequences of decentralization), by: developing statements of institutional mission to provide internalized guidance for staff members; creating appropriately constituted, interlocking work groups; using meetings to coordinate activities; designing jobs in terms of responsibilities and relationships between job-holders; developing systems of accountability to link staffs to managers.

Inasmuch as our project's method was exploratory, we intend that our presentation be interpreted as suggestive rather than prescriptive. We hope that the issues presented will help the reader reflect upon organizational matters that may have important consequences for the delivery of services to institutionalized children.

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APPENDIX A

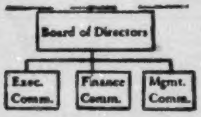
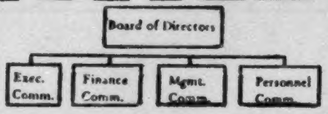
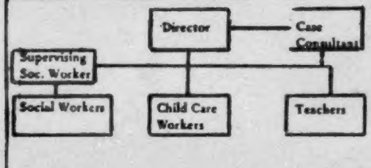
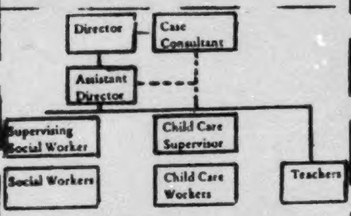
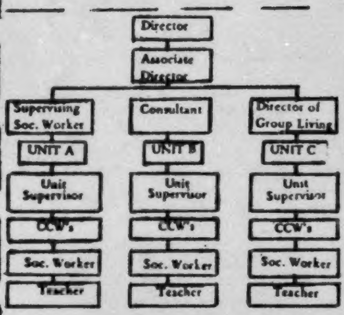
Introduction to the Chart

The chart depicts differences in organizational characteristics of children's residential centers among various stages on a continuum: centralized/decentralized organization. The first column lists organizational variables that characterize a CRC. Columns 2 through 7 describe typical differences in these variables as they occur in more and less centralized institutions.

The chart does not describe particular institutions, nor does it prescribe specific organizational designs. It is a composit of organizational characteristics that have appeared to us to be associated with varying degrees of centralization and decentralization.

The chart can help the reader identify organizational characteristics that are consistent with and may be instrumental in implementing more and less centralized management. (The main text discusses the relative suitability of centralized management to custodial/nurturing settings and decentralized management to settings that provide individualized treatment.) For example, the chart indicates how centralization typically is decreased by delegating professionals, then supervisors, authority to make operational decisions. The movement toward decentralization is culminated by further shifting decision making to interdisciplinary teams that assume responsibility for the care and treatment of children and that are organizationally related to institutional management through accountability procedures. The chart also suggests how custodial/nurturing functions can be integrated with treatment components so that both kinds of services can be provided in an integrated, and therefore maximally effective, manner.

ORGANIZATIONAL TRANSITIONS CHARACTERIZING CHILDREN'S INSTITUTIONS MOVIN

CHANGING ORGANIZATION CHARACTERISTICS	CENTRALIZED			
MISSION	To provide care for the dependent, neglected and delinquent child Reason for placement: child's own maladjustment			To provide ex to the emotio growth of the
PRIMARY TASK	Socialization Education Criteria for successful placement: 1. Child is on the road towards being a good citizen 2. Child is an asset to the community			Indiv Criteria fo improv commu
PROGRAM TYPES	Residential (cottage plan) On-grounds school or use of school in the community.	Group homes administratively connected to the residential institution		
TREATMENT CHARACTERISTICS	Custodial—Clinical Long term Contact with family restricted Children classified according to age or manifested behavior	Involvement of parents in therapy sessions Treatment is designed for categories of children (delinquents, mentally ill, neglected, etc.) with similar histories and problems Growing awareness of the importance of the living experience as a vital element of treatment	Shorter term placement (0-3 years) Treatment designed by highly trained professionals after relatively brief contact with child	Attempt to esta living with a the therapy)
ORGANIZATION BOARD OF DIRECTORS STRUCTURE	 Board of Directors Exec. Comm. Finance Comm. Mgmt. Comm.	 Board of Directors Exec. Comm. Finance Comm. Mgmt. Comm. Personnel Comm.		
CHARACTERISTICS	Board members have the reputation of "inspectors." The director then becomes the liaison between Board and staff.	Board members drawn from different professions and have skills which guide and assist the director Staff interests represented by Personnel Committee Staff representation on the committee	Board estranged from the overall program. There is focus on specific interest and expertise, e.g., finances and budget, buildings.	Considerations an Board in order to of the program an
AGENCY STRUCTURE	 Director Case Consultant Supervising Soc. Worker Social Workers Child Care Workers Teachers	 Director Case Consultant Assistant Director Supervising Social Worker Social Workers Child Care Supervisor Child Care Workers Teachers	 Director Associate Director Supervising Soc. Worker Consultant Director of Group Living UNIT A UNIT B UNIT C Unit Supervisor CCW's Soc. Worker Teacher	UNIT A TEA Leader CCW's Professionals Teacher Child Placement worker Paren
CHARACTERISTICS	Centralized Hierarchical Departmentalized	Some decisions delegated to professionals because of their expertise Continuous effort to achieve coordination between departments, i.e., cottage, social service, school	Location of social workers and cottage staff in the same functional unit to enhance necessary and informal communication	
STAFF CHARACTERISTICS	More clinicians introduced into the program as traditional child caring methods were no longer considered effective by the administration Clinical staff exists in parallel with cottage staff	Theoretically treatment decisions shared between clinicians and child care staff – actually, clinicians dominated the decision making process.	Staff assigned to units.	Director: delega management; ac vironmental rela and outside acti direction for pla Staff org *Arrows indi

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...RIZING CHILDREN'S INSTITUTIONS MOVING FROM A CENTRALIZED TO A DECENTRALIZED STRUCTURE

DECENTRALIZED

To provide experiences which contribute to the emotional, social and educational growth of the child

To provide experiences which contribute to the emotional, social and educational growth of the child

Reason for placement: child's own maladjustment

Individualized treatment

Individualized treatment

Criteria for successful placement: improved adjustment in the community

Criteria for successful placement: Improved adjustment in the community

Residential (cottage plan)
On grounds school or use of school in the community
Group homes
Day treatment
After care homes

Day treatment
After care homes

...horter term placement (0-3 years)

Short term placement (9-13 mos.)

Involvement of parents in treatment program

Community based programs developed in collaboration with interest groups

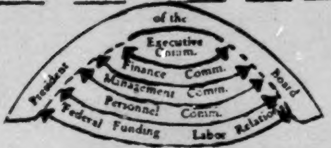
Individualized treatment plans for each child

Evaluation and research are essential parts of the program

...atment designed by highly trained ...essionals after relatively brief ...act with child

Attempt to establish planned and controlled living with a therapeutic purpose (milieu therapy)

Treatment at maximum efficiency and minimum duration – consistent with needs of children or families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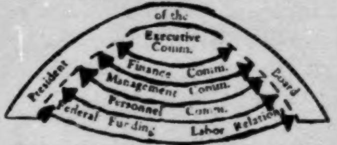
President
Board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Board

... estranged from the overall program. ...is focus on specific interest and ...tise, e.g., finances and budget, ...ngs.

Considerations and attempts to reorganize the Board in order to encourage better understanding of the program and more involvement

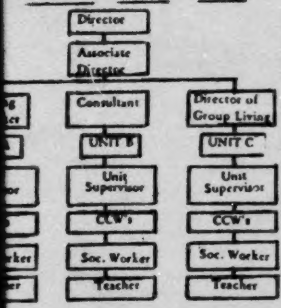
Program evaluation and research data used by Board and Administration in determining future plans

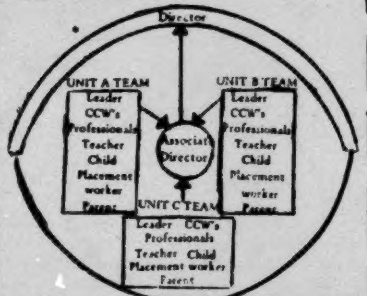
Staff representation on all committees to enhance sharing of information

Federal Funding
Labor Relations
growing interest

Staff representation on all committees

Board actively interprets the agency to the community


Director
Associate Director
Consultant
Director of Group Living
UNIT B
UNIT C
Unit Supervisor
Unit Supervisor
CCW's
CCW's
Soc. Worker
Soc. Worker
Teacher
Teacher


Director
UNIT A TEAM
Leader
CCW's
Professionals
Teacher
Child Placement worker
Parent
UNIT B TEAM
Leader
CCW's
Professionals
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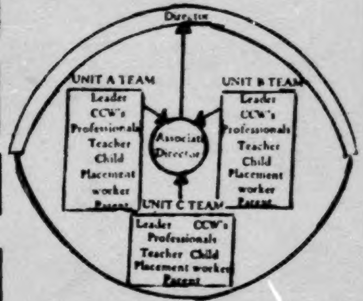
Parent
Associate Director
UNIT C TEAM
Leader
CCW's
Professionals
Teacher
Child Placement worker
Parent


Director
UNIT A TEAM
Leader
CCW's
Professionals
Teacher
Child Placement worker
Parent
UNIT B TEAM
Leader
CCW's
Professionals
Teacher
Child Placement worker
Parent
Associate Director
UNIT C TEAM
Leader
CCW's
Professionals
Teacher
Child Placement worker
Parent

Decentralized – decisions being made at the lowest levels

Decentralized

...on of social workers and cottage staff ...ame functional unit to enhance ...ry and informal communication

Staff makes use of everyone in the agency as a resource to develop skills and understanding related to individualized treatment

Accountability is based on criteria that are clear and understood by the staff

Accountability is based on criteria that are clear and understood by the staff

Director: delegates responsibilities to inside management; accepts responsibility for environmental relations; coordinates both inside and outside activity to give the institution direction for planning.

Administration responsible for the integration and coordination of an organizational structure which supports individualized treatment provided by teams.

Staff assigned to units.

Staff organized into unit teams

*Arrows indicate lines of accountability

An integrated team accepts responsibility for treatment – each team member recognizes and learns from the expertise of others.

An integrated team accepts responsibility for treatment – each team member recognizes and learns from the expertise of others.

' U Client

R. L. Blanke

Consultant

Organization Design Worksheet

Function: Responsibility for agency-wide staff development and Unit staff training (including Clerical staff)	Board of Trustees	Executive Director	Assoc. Exec. Director	Unit Supervisor	Unit Coordinator	Social Worker	Child Dev. Counselor	Children	Sup	
Who has operating responsibility? (Makes operating decisions)				✓						
Who is typically involved in the process?					✓					
Who evaluates results and effectiveness?			✓							

What information is appropriate for evaluating results and effectiveness? How does evaluator get information?

1. How was money spent
2. Was the program effective

What is the evaluation and feedback cycle? How often? What form?

Comments Unit supervisors want responsibility for the design f
of this item.
Unit Coordinators want to participate in design it + implementat
for program staff roles.

' U Client

R. L. Blankenberg #2
Consultant Date 5-30-73

Organization Design Worksheet

ponsibility wide opment and raining ical staff.	Board of Trustees	Executive Director	Assoc. Exec. Director	Visit Supervisor	Visit Coordinator	Social Worker	Child Dev. Counselor	Children	Support Staff	Clerical Staff		
(Makes ns)				✓								
					✓							
ults ?			✓									

is appropriate sults and ow does ormation?

1. How was money spent
2. Was the program effective

ation e? How often?

i supervisors want responsibility for the design function stem.

Coordinators want to participate in it design implementation function ram staff roles..

APPENDIX B

APPENDIX C
Organization Design*

Introduction

Red Rock is a nonprofit center for the residential treatment of emotionally damaged boys and girls aged 18 to 13. Average residency is 37 children in four cottages on the agency's main campus in a residential area, and six boys in a prototype satellite home in a nearby community. Children are accepted through county and private placement.

Analysis

Although this section describes a series of interventions intended to design and implement a formal organization at Red Rock, the reader should not infer that the agency was found to be relatively "disorganized." In comparison with other agencies, Red Rock showed many signs of being well organized. Budgets were being prepared and adhered to, staff scheduling and timekeeping were being accomplished efficiently, and the kitchen was doing an excellent job with limited resources. The problem was the organization of the agency's resources to perform child treatment. The staff was typically less clear on their role in the treatment of children than on any other major aspect of their jobs.

In the absence of a formal treatment organization, an informal conflict had developed between the staff primarily concerned with child-caring activities (e.g., cottage staff) and those concerned with treatment activities (e.g., social workers). The cottage staff, for example, believed that they knew the children better than the social workers (who, after all, had such limited contact with the children, and usually under such artificial conditions) and therefore saw their inputs as somewhat superfluous to the child's experience at Red Rock. Social workers, on the other hand, tended to take a complementary view: The cottage staff was quite competent at performing the child-caring activities (wiping noses and tucking in bed) but with their lack of appreciation for the body of knowledge in the field of child development and therapy, they really couldn't be expected to contribute much to the treatment of the child's complex emotional problems.

---

* This section was written by Tom Hallam, who was the organizational consultant for Red Rock.

Strategic Context

The interventions in this section took place in the sixth month of the consultation year. At that time the consultant had completed a period of orientation and observation, and had completed several interventions with varying degrees of success. The earlier interventions had been exploratory, and did not focus on the agency's formal organization. Concurrent with this intervention series, the consultant and the agency agreed to focus the remainder of the consultation on the development and implementation of a model treatment program based on the design generated as an outcome of these interventions.

Intervention Objectives

The objective of these interventions was to formally organize the agency's staff to perform the effective treatment of children. The organization would be formal, in the sense that it would be reflected in a document adopted by the agency in lieu of any others. Further criteria were that it would support team treatment and would provide a means for program evaluation.

Interventions and Outcomes

The intervention begins with a meeting between the consultant, the agency executive director, and the assistant director. The consultant, based on his prior 5 months of experience with the agency, described many aspects of the deficiency in the organizational structure of the treatment program. Some of the important aspects were the lack of treatment plans to serve as a guide to action by cottage staff, the inadequate utilization of social workers as treatment resources, and the lack of coordination among the various people interacting with a child over the course of a day. For each aspect, the consultant suggested some possible methods for improving the condition. In discussing these individual aspects, the three men conceptualized a new treatment organization, formed around treatment responsibilities rather than typical tasks. This was seen as a better organization, embodying several new concepts.

It was decided that the task of designing the new formal organization should be performed by the treatment staff. After the staff was introduced to the thinking that had already been done, the consultant met with the staff to discuss the idea of redesigning the treatment organization. An important part of this meeting was the staff's seeking and receiving assurances from the executive director that they were truly being offered the opportunity to redesign the organization within clearly stated constraints. At this meeting, the setting for the organization design activity was also decided. It would be accomplished in one day, away from the campus, following an approach to be developed by the consultant.

The organization design workshop, as the off-campus meeting came to be called, proceeded as a logical sequence of five exercises. First, the group arrived at a consensus statement of the purpose of the treatment program. Second, the group developed an inclusive list of all the responsibilities associated with that purpose. Third, each role group (i.e., all social workers form a role group) met to develop their position on each responsibility. Fourth, representatives from each role group met to negotiate conflicts in the positions developed in the preceding step. Fifth, the entire group discussed the organizational consequences of the new design. Each exercise will now be described more fully.

In developing a consensus of the program's purpose, the group reconciled their previous individual thoughts into a single representative statement. The purpose of the exercise was to provide the individual participants with an explicitly common starting point for the design activity, and to give them an appreciation of each other's perspectives.

Prior to the workshop, the individuals were asked to list what they considered to be important responsibilities in the treatment program, and these lists were the starting point for the inclusive list. The purpose statement was put at the top of the chalkboard, and before any responsibility was placed on the board it was tested to verify that it supported the purpose. The list also was checked against the Executive Director's constraints to assure that they were being satisfied.

Each role group then met separately and developed a consensus position on each responsibility. Their position could be that they wanted to assume responsibility, they wanted to share responsibility with some other group, or they didn't want responsibility. Each group chose a spokesperson to negotiate for them with the other groups.

The negotiation between role group representatives took place in a "fish bowl." The represented individuals were not permitted to communicate with their negotiator. The negotiation proceeded through the list of responsibilities item by item. The rights of the represented individuals were protected by permitting anyone at any time to call a 5-minute caucus of the role groups. Role groups may, during caucus, select a new negotiator.

The implementation planning is only a start at exploring the consequences of the new program design. The group began by looking at the meetings that were regularly held in the agency before the workshop, to decide if they were any longer necessary or appropriate. The implementation is the transfer from abstraction to reality, the fleshing out of the skeleton. The start of implementation is included as a part of the workshop to provide for a transition for the participants back to the reality of the agency.

Consultant's Description of the Reorganized Institutional Structure

The workshop produced an organization design for the treatment program that was substantially different from the prior model. Treatment plans formulated in terms of specific behavioral objectives for each child provided the data needed to satisfy the monitoring and evaluation requirement. The core of the treatment process was the treatment team composed of a social worker, a child care supervisor, and a child care staff. The child care staff's special skill was seen to be in their ability to develop close relationships and mutual understanding with the children.

Complementary responsibilities were designed for the supervisor and the social worker: the social worker responsible for the formulation of clear and reasonable treatment plans and the supervisor responsible for the child care staff's ability to facilitate the child's progress toward the goals in his personal treatment plan. The plans and progress would be reviewed regularly by the assistant director, and such review would form the basis for his evaluation of the team's performance. That is, of course, an overly simple summary of the program design.

One week after the workshop, one of the supervisors resigned (for reasons unrelated to the design process, to accept a position he had applied for months earlier). The staff viewed the vacancy created by his departure as an opportunity to improve the design of the supervisory levels of the treatment program, and created a new position of unit supervisor. This new supervisory position differed from the old one in that the new supervisor was also to perform the duties of child care staff and was a member of only one team. The team, then was composed entirely of people actively working in the treatment of children.

Four weeks after the workshop, the staff devised a method for selecting candidates for the new supervisory positions using criteria based on the program model in an open process.

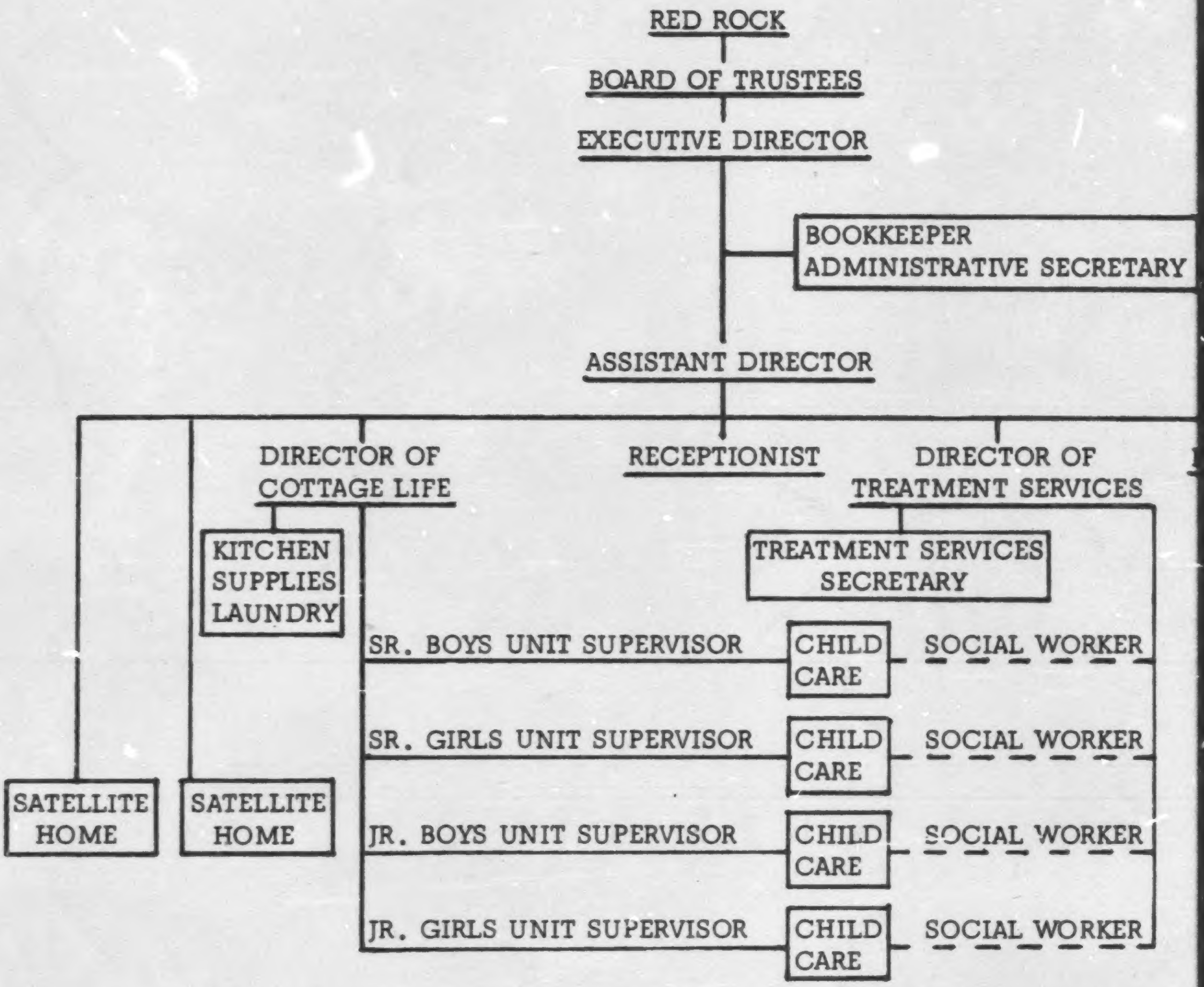
Seven weeks after the workshop, newly formed treatment plans were in effect for many of the children, and the teams were reporting a marked improvement in their ability to make observable progress with these children.

Ten weeks after the workshop, the treatment plans and progress reviews were begun, with the review participants developing the basic formats for the treatment records and the review.

Fifteen weeks after the workshop, a team devised an experimental method for involving parents in the treatment process. They developed this process, within the new design, as a way to help them meet their responsibility for children's progress toward goals that would support their successful return to their families.

At this point the program model was formalized in a working paper, Figure II. The first sheet diagrams the reporting relationships for the four autonomous treatment teams, and the management structure of the support services as well. The next two sheets define the jobs in the treatment program in terms of the responsibilities they have accepted. The last sheet shows the schedule of standard meetings established to maintain the program. The working paper only represents the program as it had progressed through 4 months. Shortly after it has been issued, the social workers changed their assignments so each individual would be the member of one team, a move intended to further each team's working independence and to allow each social worker to build an identity with a team.

The last month of the consultation was devoted to implementing a mechanism for an ongoing self-evaluation and improvement process in the treatment program, to allow for its continual growth. This was done by setting aside a day-long session for reviewing the progress that Red Rock had made in the 6 months of the model treatment program and for planning future goals that the staff wanted to move toward themselves in the next step without support of consultation. After reviewing the progress that had been made, the problems encountered, and the lessons learned, the staff set future goals for themselves in the areas of personal evaluations, acquisition of new people, and in-service training. Finally, they designed a session 4 months later for a similar review and planning cycle.


RED ROCK
BOARD OF TRUSTEES
EXECUTIVE DIRECTOR
BOOKKEEPER
ADMINISTRATIVE SECRETARY
ASSISTANT DIRECTOR
DIRECTOR OF COTTAGE LIFE
RECEPTIONIST
DIRECTOR OF TREATMENT SERVICES
KITCHEN
SUPPLIES
LAUNDRY
TREATMENT SERVICES SECRETARY
SR. BOYS UNIT SUPERVISOR
CHILD CARE
SOCIAL WORKER
SR. GIRLS UNIT SUPERVISOR
CHILD CARE
SOCIAL WORKER
JR. BOYS UNIT SUPERVISOR
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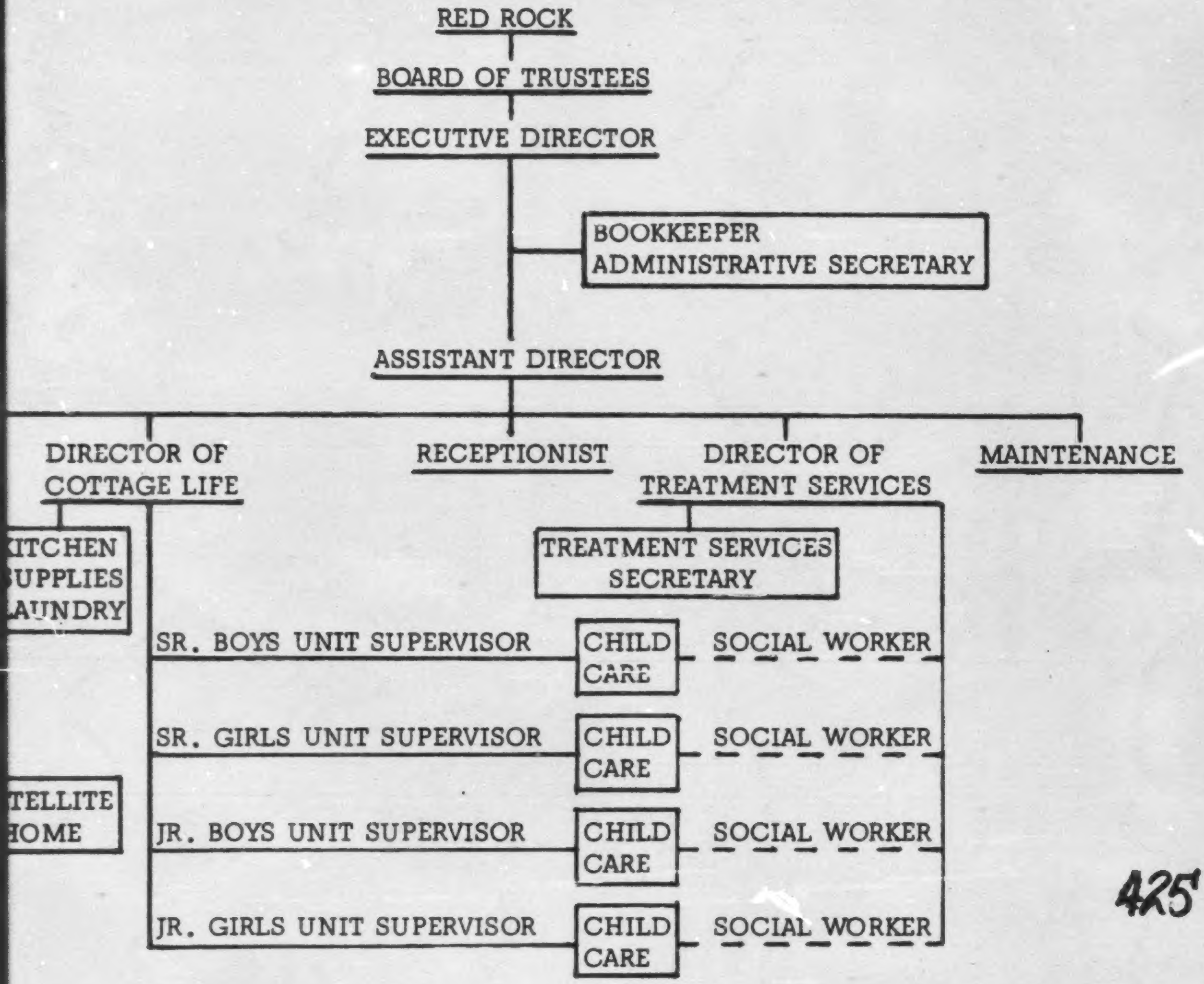
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CHILD CARE
SOCIAL WORKER
SR. GIRLS UNIT SUPERVISOR
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SOCIAL WORKER
TELLITE
OME
JR. BOYS UNIT SUPERVISOR
CHILD CARE
SOCIAL WORKER
JR. GIRLS UNIT SUPERVISOR
CHILD CARE
SOCIAL WORKER

Figure II

Figure II, sheet 2

DIRECTOR OF COTTAGE LIFE

1. Responsible for hiring, firing and supervision of unit supervisor with input from social workers.
2. Overall responsibility for the quality of cottage life.
3. Responsibility for supervision of cottage support systems (kitchen supplies and laundry).
4. Administrative and program responsibilities as delegated by assistant director.
5. Shares in staff training responsibilities.
6. In conjunction with director of treatment services conduct treatment planning and progress review meetings.
7. Responsible for the coordination of unit supervisors as well as other administrative functions.

UNIT SUPERVISOR

1. Responsible for hiring, firing and supervision of child care with input from social workers.
2. Responsible for the performance of child care teams in translating treatment goals into child care functions.
3. Carry out direct child care functions.
4. Responsibility for quality of cottage life.
5. Responsibility for clothing funds and other fiscal matters related to cottage life.
6. Responsible for inservice training re: agency policy and administration of personnel policies.
7. Direct responsibilities for scheduling and approving overtime.

Figure II, sheet 3

ASSISTANT DIRECTOR

1. Overall responsibility for evaluating the treatment program.
2. Has responsibility for maintaining all aspects of campus program.
3. Has supervision responsibilities for Satellite Home.
4. Has supervision responsibilities for supportive programs (i.e., kitchen maintenance).
5. Has recruitment responsibilities for foster homes.
6. Has hiring, firing and supervision responsibilities for:
   a) cottage life supervisor
   b) chief social worker
7. Has responsibilities for initial filling of unit supervisor positions.
8. Has fiscal responsibilities as they relate to the above.
9. Has campus administrative responsibilities (PD back-up responsibilities).
10. Has project and committee tasks with the board of directors as delegated by the executive director.

DIRECTOR OF TREATMENT SERVICES

1. Supervise, hire and fire social workers.
2. Overall responsibility for the quality of the treatment program.
3. Would be responsible for covering other social work duties.
4. Would have other administrative duties as delegated by the assistant director.
5. In conjunction with the director of cottage life conduct treatment planning and progress review meetings.

SOCIAL WORKER

1. Responsible for the establishment of reasonable, measurable treatment goals for their case load.
2. Responsible for monitoring progress toward treatment goals.
3. Responsible for intake and discharges and family after care, including foster home and development.
4. Responsible for initial and ongoing evaluation of team members' ability to understand treatment goals and their ability to carry out concepts in their child caring duties.
5. Shares responsibility in staff training.
6. Responsible for specific therapy services, e.g., individual and group treatment contracting outside diagnostic and professional therapy.

Figure II, sheet 4

MEETINGS NECESSARY TO CARRY OUT RESPONSIBILITIES OF AGENCY

1) Unit Team Meetings (Weekly as previously scheduled)	Unit Supervisor Social Worker Child Care of that Unit
2) Assistant Director Staff Meeting Thursdays 1:30 to 2:30	Assistant Director Director of Treatment Services Director of Cottage Life Unit Supervisors Social Workers
3) Treatment Goals and Prog. Meetings Week #1 2-3 Jr. Boys 3-4 Sr. Girls Week #2 2-3 Jr. Girls 3-4 Sr. Boys	Director of Treament Services Unit Supervisor of Unit Social Worker of Unit Director of Cottage Life
4) Administrative Meeting Wednesdays 10-11	Executive Director Assistant Director Director of Cottage Life Director of Treatment Services
5) Unit Supervisor Meeting Tuesdays 1-2	Director of Cottage Life Unit Supervisors of Cottages

APPENDIX D

Some Suggestions for Behavioral Science Consultants at Children's Residential Centers

Traditionally, behavioral science consultants (psychologists, social workers and psychiatrists) at children's residential centers focus their efforts on case consultation or on staff development and training. Ordinarily, they do not address organizational issues. Most appear to feel that organizational issues are beyond their purview; that they are not prepared, either by training or by experience, to act in that arena.

We are hopeful that our text--although addressed to institutional managers--will serve to identify organizational issues in which behavioral science consultants may also be interested. If they feel that such organizational issues can be of importance to staff efforts to provide effective individualized treatment, they may want to try to help institutions deal with them.

This appendix outlines one possible strategy for organizational consultants in children's residential centers. The strategy is a composite developed in the course of our combined experience in our project institutions.

Some Steps in a Consulting Strategy

Depending upon whether a consultant is new to an institution or already has experience in it, he may want to consider some or all of the following suggested steps in a process of organizational consultation:

1. Establishing a relationship with the director.

   Ordinarily, a consultant is invited to an institution at the request and with the approval of its director. A first, highly desirable step is to develop a mutually clear understanding of what the director wants and what part he is willing to play in the consultation, and for the consultant openly to discuss his frame of reference, his intentions, and something of the process he has in mind. For an organizational consultant, it will be important that the director understand that he is a consultant to the organization, not personally to him.

2. Establishing initial credibility.

The director and consultant should agree on how the agency should be informed about the consultant and his availability. One effective way is for the director, in writing and in other ways, to announce the consultant's availability and to signal his support for the consultation. The consultant and director should jointly draft a carefully worded statement (meaning exactly what it says) about who the consultant is, his background, the general objectives of the consultation, and the general terms of the contract between the institution and the consultant--for example, the frequency and duration of his availability. The statement might also describe the first phase of the consultation--for example, that the consultant wants to spend some time collecting information about the institution by talking to staff members throughout the organization.

This kind of statement should establish the consultant's initial credibility with the institution's staff. His credibility over the long term will depend upon his integrity, sensitivity, ability to deliver what he promises, and his desire and ability to be helpful.

3. Forming a "utilizing group."

For organizational consultation to work, the organization-as-client needs to work collaboratively with the consultant. One way to develop a collaborative relationship is for the institution to identify a group of staff members that will represent it in its relationship with the consultant. That "utilizing group" may include the director and members of the administrative, professional, child-care and school staff. To be effective, the group should include the most energetic, influential, flexible and forward-looking staff members that the institution can identify. The group's boundaries should be open--that is, its membership (and its leadership as well) should be open to changes as the focus of its efforts with the consultant changes.

4. Working with the utilizing group.

One general format for a collaborative relationship between the consultant and the utilizing group has already been described in the text (Chapter IX, pp. 82-85). Essentially, it consists

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of the collaborative identification of institutional issues on which they wish to focus, the negotiation of "contracts" or agreements about how they plan to work together on each issue, and the sharing of responsibility for planning, action and assessment.

A first contract might be that the consultant will collect information about the institution, analyze it and identify what appear to be the important issues with which the institution might want to deal, and that in return for his presentation of that analysis, the utilizing group will identify those issues to which they want to give priority (perhaps adding some of their own or changing ones that are presented).

5. Developing projects for an action phase.

The consultant and the utilizing group may establish several work groups, each of which is responsible for planning and working with the consultant on some particular priority that has been identified. The institution should agree to make available resources so that these work groups can enlist the help of outside resources (if needed) or use inside resources in order to carry out desirable programs. A priority in most institutions is likely to be some effort to review and perhaps modify the organizational design of the institution, to enable it to provide services more effectively. Any of the issues discussed in the text might become a focus for work during the action phase of the consultation--and, indeed, there likely are many others.

6. Setting long-range goals.

Although the action phase likely will become focused on particular issues that may be addressed over the relatively short term, a long-range goal for consultation should be developing an institution's capability (as an open and learning system) to continue on its own to be innovative and self-renewing. During the consultation experience, the utilizing group, it is hoped, will develop such skills and can continue to provide leadership to the institution in identifying areas in which improvement is needed, organizing activities to bring about those improvements, and assessing the outcomes of those activities. A particularly important function of such a group is its location on the boundary of the institution so that, knowing institutional needs for new information and innovative ideas, it can keep a watchful eye on research literature and new practices in the field.

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7. Evaluating the consultation experience.

The consultant can set an example for the institution by planning an evaluation of the consultation experience with the utilizing group. By his own example, he helps to establish an institutional ethic of openness and willingness to review performance.

Doing organizational consultation likely will require that the consultant take a stance that is different from the one he is used to--at least if he works somewhat in the manner described above. Ordinarily, the organizational consultant is much more active than the traditional consultant in reaching out into the organization for information, in taking the initiative for identifying areas of special interest and for suggesting actions that should be taken. Although the organizational consultant we have described does not impose goals on the institution, he is very strongly goal-oriented. The organizational consultant likely will take much more responsibility for the outcome of his efforts than does the traditional consultant.

For traditional behavioral science consultants, learning to play a variety of new roles may require experimentation, a willingness to take risks and a willingness to learn something of a new trade. However, correcting organizational characteristics that impede effectiveness can lead to fundamental changes that ultimately will be of great importance to the institution's clients.